STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

October 15, 2012

Senator Dean Kirby, Chairman
Senate Public Health and Welfare Committee
212-D New Capitol Building
Jackson, Mississippi 39201

Representative Bobby Howell, Chairman
House Medicaid Committee
104-A New Capitol Building
Jackson, Mississippi 39201

Dear Sirs:

We are pleased to present three Mississippi Division of Medicaid reports, prepared in response to requirements for four proposals in 2012 legislation. Section 5 of House Bill 421, as passed by the Mississippi State Legislature, gave the following direction to the Division of Medicaid (DOM):

"(1) The division shall develop proposals for the following:

**(a)** The division shall develop a plan for the APR-DRG reimbursement methodology which increases such payments in order to reduce or eliminate Medicare Upper Payment Limits (UPL) program payments;

**(b)** The division shall develop a plan to replace the existing hospital assessment provided in Section 43-13-145 with other possible revenue systems, including the possibility of a net inpatient revenue assessment;

**(c)** The division shall develop a plan providing revisions to the current reimbursement methodology for prescription drugs.

**(d)** The division shall develop a plan providing revisions to the current reimbursement methodology for nursing facility service.

(2) The division shall not implement these plans, but shall submit the plans to the Public Health and Welfare Committee of the Senate and the Medicaid Committee of the House no later than October 15, 2012, including necessary legislative recommendations."

These reports document the division's progress to date and outline the next steps for moving forward. Our approach and time table are discussed in detail within these reports. If you have any questions, please do not hesitate to contact me. Thank you for your time.

Sincerely,

David J. Dzielak, Ph.D.
Executive Director

Suite 1000, Walter Sillers Building, 550 High Street, Jackson, MS 39201, (601) 359-6050

# Medicaid Hospital Fund Report

**Mississippi Division of Medicaid**

October 2012

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# 1. Executive Summary

The Mississippi Division of Medicaid (DOM) continues to pursue hospital reimbursement programs that enhance access to high quality health care services for Mississippi Medicaid beneficiaries and uninsured citizens, while simultaneously encouraging cost efficiency within the hospital health care delivery system.

The (DOM) is committed to working with health care providers, legislators and other stakeholders to foster an open collaborative environment for sharing ideas, evaluating program alternatives, and coordinating the adoption of program changes that meet these goals.

## 1.1 Legislative Directive

Section 5 of House Bill 421 of the Mississippi 2012 regular legislative session instructs DOM to develop proposals related to hospital payment, as follows:

**(a) "The division shall develop a plan for the APR-DRG reimbursement methodology which increases such payments in order to reduce or eliminate Medicare Upper Payment Limits (UPL) program payments";**

**(b) "The Division shall develop a plan to replace the existing hospital assessment provided in Section 43-13-145 with other possible revenue systems, including the possibility of a net inpatient revenue assessment."**

HB 421 further instructs that **"The division shall not implement these plans, but shall submit the plans to the Public Health and Welfare Committee of the Senate and the Medicaid Committee of the House no later than October 15, 2012, including necessary legislative recommendations."**

Section 2 of House Bill 421 of the Mississippi 2012 regular legislative session states, **"The division is authorized to implement an Ambulatory Payment Classification (APC) methodology for outpatient hospital services."**

## 1.2 Division of Medicaid Approach

DOM is continuing work on these legislative directives. This report is being submitted to comply with the October 15, 2012 requirement in legislation and documents the progress to date and outlines the next steps. Finalized proposals and legislative recommendations will be submitted no later than the first quarter of 2013. DOM's approach and time table for each of the directives is discussed in detail within this presentation.

DOM has made significant progress in recent months towards the evaluation and adoption of the hospital All Patient Refined-Diagnosis Related Group (APR-DRG) inpatient and the Ambulatory Payment Classification (APC) outpatient payment systems. These systems will provide the foundation needed to evaluate changes to Mississippi hospital UPL payments. DOM is also in position to begin actively pursuing an alternative provider assessment system.

# 2. Summary of Division Activities in Fiscal Year 2013:

Transforming the inpatient and outpatient hospital payment systems to better support DOM goals for access, quality healthcare services, and cost efficiency are complex initiatives. Medicaid program officials, hospital representatives, and other program stakeholders have collaborated to modify the payment systems to better support DOM goals. DOM's transition to APR-DRGs and APCs now aligns our Medicaid inpatient and outpatient hospital payment systems with those used by the federal Medicare program. Aligning these two systems discontinues a set of mixed incentives hospitals received between the Medicare and Medicaid programs. These accomplishments are summarized here.

**Inpatient Hospital Payment System Changes**

For the past eight years, DOM has been working on the development and implementation of an APR-DRG inpatient hospital payment system. DOM believes this form of inpatient hospital payment will generate several tangible benefits for the Medicaid program:

- The APR-DRG payment system reimburses hospitals using a standard base price that is the same for all hospitals (or groups of hospitals). This standard base price is increased or decreased based on the intensity of the health care services the patient receives as measured by the clinical diagnoses and the specific health care procedures performed. These prices are paid regardless of the actual cost a hospital incurs providing the service.
- Since APR-DRG payments can increase dramatically with the intensity of the care needed, DOM believes this form of payment will continue to encourage broad-based access to needed health care services for Medicaid recipients.
- The APR-DRG price-based reimbursement system replaces the cost-based per diem reimbursement system. The cost-based per diem reimbursement methodology did not meaningfully encourage cost efficiency, and, in fact, future payments were reduced whenever measured cost decreased. The incentives within the cost-based system inadequately supported DOM goals for cost-effective hospital health care services.

Key Features of the APR-DRG Payment System Implemented October 1, 2012:

- APR-DRG payments were implemented for admissions starting on October 1, 2012.
- Day limits and inpatient physician visit limits were discontinued.
- APR-DRG payments will apply to all Mississippi and out-of-state Medicaid inpatient hospital claims, except Indian Health Services reimbursed on a per diem basis in accordance with Federal Law.
- APR-DRG payment rates for state fiscal year 2013 were developed to be budget neutral with the six months of claims paid October 1, 2010 through March 31, 2011.
- DOM is using the APR-DRG grouper, version 29, developed by 3M Health Information Systems.
- The APR-DRG base price effective October 1, 2012 is $6,223.
- To ensure access for Medicaid beneficiaries to specialty services DOM has included within the APR-DRG payment system policy adjustors for obstetrics, neonates and normal newborns services, pediatric and adult mental health (MH) services, rehabilitation services, and transplant services . These policy

adjustors increase the APR-DRG relative weights and therefore, increase the APR-DRG payments for these claims. The DOM policy adjustors are as follows:

    - Obstetrics, neonates and normal newborns - 1.40
    - MH pediatric policy adjustor - 2.08
    - MH adult policy adjustor - 1.75
    - Rehabilitation policy adjustor - 2.11
    - Transplant policy adjustor - 1.50

- To protect hospitals from excessively costly or long lengths of stays DOM has also adopted cost and day outlier features that result in additional Medicaid payments when an acute care hospital stay exceeds the cost outlier threshold, or the inpatient psychiatric hospital stay exceeds the day outlier threshold.
    - The cost outlier payment to hospitals is calculated at 60% of the difference between the hospital's estimated loss per claim and $30,000. The day outlier payment is $450.00 per day and applies to approved MH stays greater than 19 days.

**Outpatient Hospital Payment System Changes**

Simultaneously with DOM's pursuit of APR-DRGs, DOM also is developing and implementing a new outpatient hospital payment system. DOM is transitioning to an ambulatory payment classification (APC) system. This reimbursement methodology is used for both Medicare and private insurance claims.

- Phase I of the APC system also is a price-based payment system. Prices are established for the spectrum of outpatient hospital services provided. These payments better match the payment amount to the intensity of the health care services provided.
- APCs are groups made up of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that share common types of services or common types of service delivery.
- Phase II of the APC system will recognize that when multiple outpatient procedures are performed within a single visit, the additional procedures are less costly. The APC system will provide for payment discounts on the additional procedures. This creates a better match between provider payments and the resources hospitals devote to outpatient care.
- Since APC payment rates increase with the intensity of the services provided, this payment system will encourage broad-based access to needed outpatient hospital services for the Medicaid population.

Key Features of the APC System:

- APC payments will be implemented in a two phased approach.
- Phase one started September 1, 2012. This system included the following features:
    - The Medicare conversion factor for the Jackson, Mississippi area was used to compute APC rates. For each outpatient service or procedure with an APC, the fee is 90% of the APC rate times the units. For those procedures where no APC rate has been assigned, outpatient services will be paid 90% of any Medicare fee times the units. For those services where a Medicare fee or APC rate is not available, payment will be made using the Mississippi Medicaid fee times the units.
    - The 5% payment reduction in reimbursement implemented by the Mississippi Legislature effective May 1, 2002 continues.

- Emergency visit limits and blood unit limits were discontinued.
    - Claims are paid at the lesser of the calculated payment or charges on a claim level basis.
    - Physician administered drugs will be paid only when a valid National Drug Code (NDC) is included in the claim. A NDC is a unique 10-digit, 3-segment product identifier used in the United States for drugs intended for human use.
- Phase two will start on December 10, 2012. At that time the following payment features will be used on the outpatient hospital payment system:
    - Discounting will be implemented for procedures with status indicators "T" (a status indicator assigned by Medicare for a significant procedure paid by APC for which the multiple procedure discount does apply) and "MT" (a status indicator established specifically for the MS Medicaid program to discount a significant procedure that Medicare does not indicate for discount) . The first allowed line will be paid at 100% and other lines with status indicators "T" and "MT" will be paid at 50%.
    - Two fees will be used for observation care. (higher for emergent and lower for non-emergent.)

**Supplemental Payments**

- The Medicaid program will continue to comply with State legislation in regard to hospital supplemental payments and continue the inpatient hospital supplemental payment program (often referred to as the upper payment limit (UPL) program).
- This program increases Medicaid inpatient hospital payments within each ownership class (state-owned, non-state government owned and privately owned hospitals) up to the federal UPL.
- Utilizing this program ensures that all available federal participation in our inpatient hospital payment system is obtained.
- To ensure Mississippi citizens are not burdened with the cost of our hospital supplemental payment program, the state's costs for these programs will continue to be funded through the hospital provider assessment program, in accordance with State law.

**Uninsured Services**

The Medicaid program is committed to ensuring access to high quality health care services for uninsured citizens. DOM is able to pursue this goal through the disproportionate share hospital (DSH) program. Annually, the Medicaid program receives a federal DSH allotment (federal Medicaid funds) that can be used to reimburse hospitals for inpatient and outpatient hospital services provided to uninsured patients.

DOM plans to continue to utilize all of these funds to ensure that uninsured citizens have access to needed heath care services. DOM believes there will be adequate funds to compensate all DSH eligible hospitals for virtually 100 percent of the costs they incur providing services to uninsured Mississippians again in fiscal year 2013.

# 3. Additional Potential Changes to Current Payment and Program Funding Methods

## 3.1 Goals and Objectives

In the coming months DOM plans to further address the requirements from HB 421. Because of the efficient implementation of the newly authorized payment systems, it makes sense to prepare and evaluate models based on expected results from these implementations. The APR-DRG methodology was designed to be budget neutral with fiscal year 2011 claims payment history. As such there will be differing impacts from hospital to hospital. Some hospitals should expect to experience overall increased claims payments while other hospitals should expect to experience overall decreases. The anticipated changes in payments for each hospital must be incorporated into the DSH/UPL modeling. The financial model for fiscal year 2013 will incorporate the changes. This process is on schedule to meet the legislative requirement for an initial distribution in December. The modeling needed to develop the plans required by Section 5 of the HB 421 will use the fiscal year 2013 demonstration as a base. Due to the DSH/UPL schedule, time was insufficient to afford completion of the proposals by October 15, 2012. The current year financial model will undergo review by DOM, its contractors, the hospital industry, and the federal oversight agency. It is expected to be ready for initial distributions in December. After the December distribution is complete, revisions to the current model will be evaluated. DOM anticipates having results from this model in the first quarter of 2013.

DOM will evaluate reimbursement methodologies that increase APR-DRG payments in order to reduce or eliminate UPL payments. DOM will also evaluate alternatives for replacing the current provider assessment system.

DOM's goal will be to continue to encourage Mississippi hospitals to provide broad-based access to high quality health care services to Medicaid recipients, while continuing to implement hospital payment systems that encourage and reward cost efficiency.

## 3.2 Work Plans for Evaluation Alternatives

**Potential Inpatient Hospital Payment System Changes**
DOM supports the legislative desire to increase inpatient hospital payments to reduce or eliminate UPL supplemental payments. DOM will develop payment system models designed to evaluate options for accomplishing this goal. Once these models are ready, they will be shared with hospital representatives, legislators and other stakeholders.

There are a few potential concerns DOM believes need to be addressed through these modeling efforts. Among these are the following:

- Will using all available funding within the APR-DRG reimbursement system create financial hardships within geographic areas, among specialty hospitals, or other groups of hospitals within the state? For example will small rural hospitals remain financially viable under this type of system?

- Under existing federal regulations DOM will be required to produce UPL demonstrations annually. Large scale changes are proposed within the Medicare payment program that would impact UPL. These proposed changes could impact the DOM APR-DRG payment system.
- If APR-DRG payment reimbursement is increased up to the UPL, the state will experience increased financial risk from increases in Medicaid hospital utilization. Higher reimbursement rates result in larger program payments when utilization increases. DOM models will need to address this risk.
- Because of the interrelationship of the UPL with DSH, it may be important to maintain a limited UPL program to ensure the maximization of DSH distributions.

DOM intends to work with program stakeholders to ensure that these concerns, as well as other issues, are addressed throughout the modeling efforts.

**Potential Hospital Funding System Changes**
DOM recognizes that inpatient hospital days can generate large differences in revenues based on the type or intensity of the services provided. For example, intensive care unit (ICU) days typically generate more hospital revenue than nursery days. Yet the current patient day-based provider tax system assesses each of these days at the same rate. Therefore, DOM is very supportive of the legislative directive to evaluate alternative assessment systems, including a net inpatient revenue system.

DOM will evaluate alternatives in conjunction with the efforts for evaluating inpatient and outpatient payment system improvements. Here, too, DOM plans to involve hospital representatives, legislators and other stakeholders in evaluating reimbursement models.

## 4. Legislative Recommendations

Depending on the outcomes from these system evaluations, legislation may be needed to authorize the Division to implement desired system improvements. DOM intends to have legislative recommendations prepared for each of these initiatives by the end of February, 2013.

# Nursing Facility Legislative Report in Response to House Bill 421

**Mississippi Division of Medicaid**

October 2012

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# 1 Executive Summary

## 1.1. Legislative direction

As part of House Bill 421, Section 5, the Mississippi State Legislature gave the following direction to the Division of Medicaid (DOM):

**"The division shall develop a plan providing revisions to the current reimbursement methodology for nursing facility service.**

**The division shall not implement these plans, but shall submit the plans to the Public Health and Welfare Committee of the Senate and the Medicaid Committee of the House no later than October 15, 2012, including necessary legislative recommendations."**

This report is being submitted to comply with the October 15, 2012 requirement in legislation and documents DOM's progress to date and outlines the next steps for completion. Finalized proposals and legislative recommendations will be submitted in the first quarter of 2013. DOM's approach and time table is discussed in detail within this presentation.

## 1.2. Division approach

In response to the direction from the Legislature, DOM has formed a workgroup, comprised of nursing facility industry representatives, state staff, consultants and other interested parties. A complete list of the membership of the workgroup can be found in Appendix A to this document.

The workgroup has met four times, in Jackson (July 13, August 9, September 6 and October 4, 2012). In order to appropriately address the very complex nature of nursing facility reimbursement, the workgroup created three sub-groups to address cost reporting, case mix/acuity calculation, and quality improvement. At this time, the group is not ready to finalize their recommendations for improvement to the nursing facility payment method. We believe that further inquiry, analysis and discussion are necessary in order to make recommendations that meet the stated goals of the project. The workgroup has scheduled additional meetings to finalize recommendations. The next two meetings are scheduled for November 8, 2012, and December 13, 2012.

Please see Section 4.1 and Appendix B of this document for a description of the potential reimbursement method changes being considered.

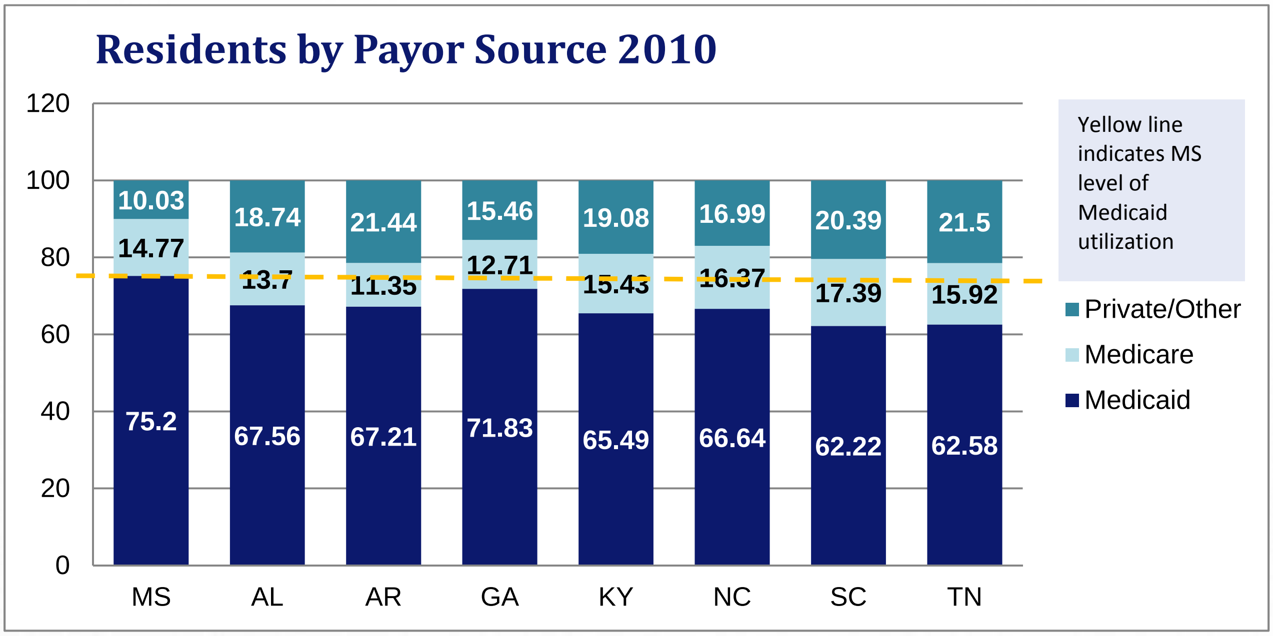
General recommendations for improving the nursing facility payment method will be finalized in the first quarter of 2013. If the legislature approves the recommendations, DOM will develop the specific changes needed through a continuing collaborative process with the long term care industry.

# 2 Medicaid's Role as a Purchaser of Nursing Facility Services

## 2.1. Medicaid's impact on the industry as the most significant payer

It is important to acknowledge Medicaid's role as the most significant payer of nursing facility services. There is a special burden on the Medicaid program to carefully consider payment policy, because of the disproportionate impact on the provider's ability to operate. As researchers have pointed out, "analysis has shown that Medicaid also plays two distinct roles as a purchaser. In the markets for most acute care services, its modest share makes it something of a follower. In the markets for most LTC (long term care) services and in certain acute care submarkets, however, its dominant role gives it greater opportunities and responsibilities. Understanding this difference is essential when conducting analysis and making decisions with regard to access, coverage, payment, and quality of care."[1]

In Mississippi, Medicaid pays for approximately 78% of nursing facility days of care. Therefore, when DOM makes a change in payment policy, it can impact the way nursing facilities do business. It can affect staffing levels, plant maintenance and administrative capabilities. All of these factors can impact access to care and the quality of care experienced by the nursing facility resident.




The dependence on Medicaid funding appears somewhat higher in Mississippi than in other states in the region, as illustrated in the above chart, derived from a published summary of the federal database of nursing facility surveys.[2]

The percentage of the general population who are residents in nursing facilities is higher than the national average in Mississippi. It is also somewhat high relative to other states in the region[3].

| Nursing Home Residents by State - Comparison 2010 | | | | |
|---|---|---|---|---|
| | Population | Nursing Facility Residents | Percentage of Population | Per thousand residents |
| Arkansas | 2,861,400 | 18,557 | 0.65% | 6.5 |
| Louisiana | 4,432,600 | 25,490 | 0.58% | 5.8 |
| **Mississippi** | **2,877,500** | **16,367** | **0.57%** | **5.7** |
| Kentucky | 4,279,400 | 23,370 | 0.55% | 5.5 |
| Tennessee | 6,243,900 | 32,060 | 0.51% | 5.1 |
| Alabama | 4,660,300 | 22,920 | 0.49% | 4.9 |
| North Carolina | 9,229,900 | 37,373 | 0.40% | 4.0 |
| South Carolina | 4,507,800 | 17,115 | 0.38% | 3.8 |
| Georgia | 9,671,400 | 32,286 | 0.33% | 3.3 |
| **US** | **305,191,100** | **1,393,127** | **0.46%** | **4.6** |

## 2.2. Outside influences on nursing facility costs

The workgroup has identified a number of issues influencing nursing facility costs. These issues will be further explored in the final report:

I. Regulatory climate,

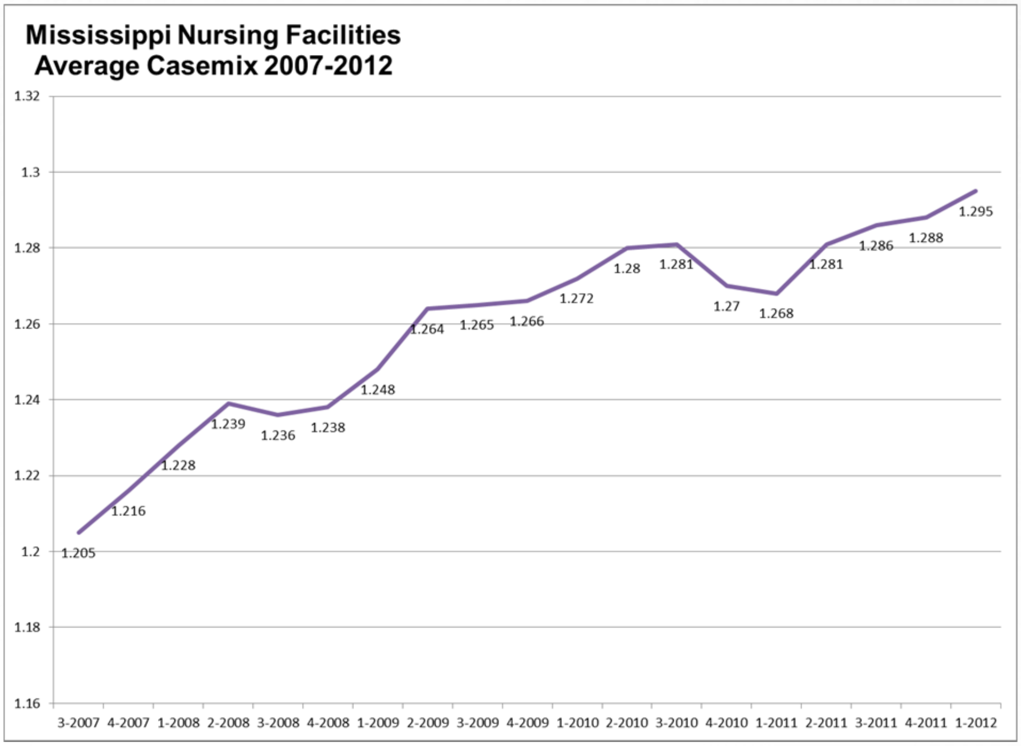
II. Increasing acuity of new residents, and

III. Availability and competence of professional staff.

## 2.3. Trends in Mississippi payment levels and acuity

Case mix describes differences in residents within a population in terms of their medical, physical and mental conditions. Mississippi's case-mix classification system utilizes the Resource Utilization Groups (RUGs) III system which measures the intensity of care and services required for each resident.

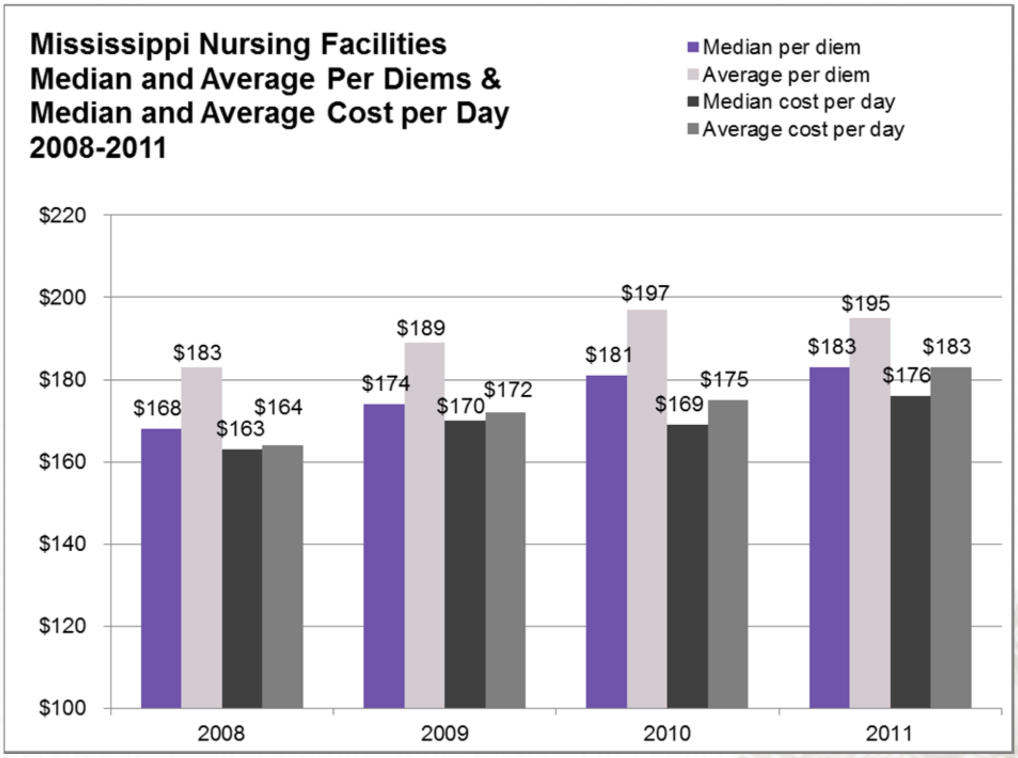
As seen in the following chart, the average case mix (measured quarterly) has increased since 2007 by 7.5%. The range of individual resident scores is from .575 to 2.839. The nursing staff resource needs of residents have experienced an increase over time. Likewise, facility costs and Medicaid payments have risen. Higher case mix indicates that nursing facilities are caring for more complex patients overall, and incurring greater costs to provide that care. This case mix measure does not tell us whether the more complex residents are Medicaid residents or not. Mississippi currently only measures the facility wide case mix. This includes the acuity of non-




Medicaid residents, including Medicare residents who typically have a higher acuity rating than Medicaid residents. A measure of Medicaid residents only would yield a different, presumably lower, result.

The facility wide case mix value is currently used in rate-setting to adjust the reimbursement for direct care (nursing) costs. As a result, DOM is paying for nursing costs that relate to the entire population of each nursing facility. Since Medicaid residents are typically less acute than other residents, the cost per day for nursing care would typically be lower for Medicaid residents. (Typically Medicare covers the higher acuity residents.)

The median DOM per diem paid for nursing facility care has risen from $168 in 2008 to $183 in 2011. Average costs per day remain at or below the per diem payment levels. As the chart indicates below, costs are consistently lower than rates, whether comparing the averages or the medians.




The median bars indicate the midline costs and rates where there is an equal number of nursing facilities with higher and lower costs and rates. The average per diems and costs exceed the medians for all years presented. The fact that the averages are higher than the medians indicates that facilities with lower costs and rates are clustered closer to the median than the facilities with higher costs and rates. Medicaid base rates have not changed since January 1, 2010, in compliance with legislative mandates to freeze rates. Per diem base rates are adjusted quarterly for the facility change in case mix. Therefore, facility rates rise when facility case mix rises.

The 2011 cost per day bars may change in the next report. Medicaid 2011 cost report desk audits are currently in process.

# 3 Background and Process

## 3.1. The current nursing facility payment method

The DOM assigns each nursing facility a payment rate specific to the facility. Each is an average rate used for billing for all Medicaid beneficiaries, whether the resident is low acuity or high acuity. The rate is derived from the facility's specific costs subject to ceilings, and is adjusted for facility acuity. The current reimbursement system establishes a cost-based prospective per diem payment rate annually at January 1. (Note: No annual rebasing has occurred since January 1, 2010.) The per diem payment established for each nursing facility is the sum of per diem rates calculated for the different cost centers. Rates are computed for:

- Direct care and care related costs,
- Administrative and operating costs,
- Property fair rental payment, and
- Return on equity capital for non-property related equity.

The rates for direct care and care related costs and for administrative and operating costs are based on actual costs as reported on each facility's annual DOM cost report trended forward and subjected to cost ceilings. The trend factors are based on a Mississippi specific market basket index. The direct care costs are case mix adjusted based on the average case mix of the facility for the cost report period. The case mix is calculated based on a resident classification system.

The resident classification system was designed in the early 1990's based on time studies and assessment information gathered from five (5) states (Kansas, Maine, Mississippi, Nebraska, and South Dakota). The classification system originally designed for the demonstration project contained forty-four (44) classifications of residents and is known as RUG III. Mississippi elected to use the Multi-state Medicare/Medicaid Payment Index ($M^3PI$), which contains thirty-five (35) classifications. Using Mississippi wage data, weights were assigned to each of the classifications. Additionally, different weights were developed and are used for residents in licensed Alzheimer's units.

The current payment method requires that resident specific data be extracted from the resident assessment tool (the Minimum Data Set or MDS record) and processed through the RUG classification system to determine the relative acuity of each resident over time. The facility case mix is calculated based on the average case mix of all nursing facility residents during the measurement period (typically one calendar quarter). The rate-setting process uses an historical measure of case mix to adjust direct care costs for each facility, which means that historical case mix affects the facility's future rate. There is a lag of one calendar quarter between changes in case mix and changes to the facility rate.

Capital costs are reimbursed through a fair rental value system. The facility and equipment are aged based on construction dates and renovation and purchase expense. The age of the facility determines the value used to calculate the rental per diem payment. Higher values are assigned for licensed Alzheimer's units.

A per diem is included for return on equity, if the facility has working capital available for use by the facility. The per diem is calculated using certain balance sheet amounts and a combined return rate and risk adjustment of nine and one-half percent.

## 3.2. Goals for improving the nursing facility payment method

Thirteen goals have been identified by the workgroup as listed below. See Section 4.2 of this report for a summary of how these goals are prioritized by the workgroup.

The goals of the Nursing Facility workgroup are:

1. Maintain access to nursing facility care for Medicaid beneficiaries
2. Provide stability and predictability in revenue to the marketplace
3. Provide resources to meet quality of care, quality of life and physical environment expectations of regulators
4. Provide resources to meet quality of care, quality of life and physical environment expectations of consumers
5. Promote quality care for beneficiaries
6. Timely recognition of changing costs; especially those targeted to improve resident care
7. Fairness in payments across facilities
8. Efficiency and ease in administration – Nursing Facilities
9. Efficiency and ease in administration – DOM
10. Purchasing clarity for the State (DOM)
11. Insure appropriate access to capital markets
12. Keep the nursing facility program affordable for DOM, and for the taxpayers of Mississippi
13. Assure the appropriate level of care for Medicaid beneficiaries

These goals are the benchmark against which all potential changes to the nursing facility payment method will be compared.

## 3.3. Workgroup process and status

The Nursing Facility Payment Method workgroup has met four times to date. The membership of the group is listed in Appendix A to this document.

At the first session, it was agreed that the main group would be divided into three sub-groups, each focusing on one of the following areas:

- Acuity
- Cost
- Quality

Each attendee volunteered for one of the sub-groups resulting in three (3) groups; a chairperson and scribe were selected for each group. Each sub-group is tasked with assessing the impact of particular potential changes to the nursing facility payment method.

**Acuity sub-group**
This group is assessing the impact of the RUG IV grouper vs. the RUG III grouper currently in use by DOM. The RUG IV grouper is a more current tool, meant for use with the current design of the resident assessments (MDS 3.0) which has 48 classifications rather than the 35 classifications for RUG III.

This group is also assessing the impact of using a Medicaid case mix measure in rate-setting, rather than the all facility case mix now in use.

The group requested and received data comparing these factors, and is in the process of evaluating each option.

**Cost sub-group**
This group is tasked with assessing the merits of cost-based rates vs. price-based rates. They are also reviewing the structure of the current cost-based method and investigating options for improvements. If the final recommendation is to continue with the cost-based method, they have identified some areas for potential improvement of that process.

**Quality sub-group**
The main area of discussion involves whether quality measures should be used for Medicaid payments for Mississippi nursing facilities and if so, which measure(s) should be used, how the measure should be scored, and the effect of the score on the final rate. The subgroup is also tasked with evaluating quality measures that would be meaningful to facilities for quality improvement.

This group is also assessing the merits of facility based rates vs. resident specific rates.

For a more complete discussion of the issues being addressed by each sub-group, please see Appendix B of this report, and Section 4.1, Potential Changes to the Payment Method.

# 4 Options for Changes to the Current Payment Method

## 4.1. Potential changes to payment method

The workgroup is investigating changes in four major areas. Any change made in these areas can have significant impact on facility rates. These changes can be made in almost any combination.

Besides these four major issues, there are many other related issues being discussed and considered by the workgroup. The final assessment report will include a discussion of all issues identified as relevant by the workgroup. For more detail about each of these issues, see Appendix B.

- Choice of Resource Utilization Grouper (RUG) to calculate case mix: RUG III or RUG IV
- Cost based rates vs. price based rates
- Facility rates vs. resident specific rates
- Use of the Medicaid case mix index in rate-setting

The final recommendations for changes to the nursing facility payment method could contain any combination of the above factors. Because these factors interact with each other to impact facility rates, the workgroup is carefully analyzing the impact of each decision before making a recommendation.

Recommendations about these options, and possibly others, will be included in the final assessment report.

## 4.2. A report card approach

In order to manage the complexities of considering changes to the nursing facility payment method, the workgroup agreed to adopt a “report card” approach to assessing the value of different payment method options. This approach measures how well a proposed payment method meets the stated goals of the nursing facility payment project, relative to other proposals.

The first step in developing the report card was to develop a brief description of what success would look like for each goal. This gives the workgroup a benchmark against which to grade each proposal.

The goals were ranked into three tiers; with the most critical goals in tier one. All the goals are important, but it is necessary to recognize that there may be situations where the goals are in conflict. Ranking the goals makes it easier to see the optimal choice in case of such a conflict. The goals are defined as follows:

1. **Maintain access to nursing facility care for Medicaid beneficiaries**

   We want to reward nursing facilities for providing access to a variety of quality, appropriate services in geographic locations convenient to the Medicaid beneficiaries and their families. Financially, access depends on the total funding (the size of the pie) and how the total funding is allocated by case and by facility (the division of the pie). The question of total funding is outside the scope of this process, but we will evaluate how the options perform in directing more payment toward more expensive cases and less payment toward less expensive cases.

2. **Provide stability and predictability in revenue to the marketplace**

   To what extent does a payment method give the facility control over total revenue? Does the payment method result in significant fluctuations in payment levels from both existing levels and from year to year? Does it enable facilities to make accurate forecasts of future revenue?

3. **Provide resources to meet quality of care, quality of life and physical environment expectations of regulators**

   Overall levels of payments are not dependent on the payment method. Some payment methods are, however, more responsive to changing case mix than other methods. Are the reimbursement parameters at a level where providers will have adequate resources including staffing, wage levels, benefit levels, and physical plant maintenance to meet expectations of regulators?

4. **Provide resources to meet quality of care, quality of life and physical environment expectations of consumers**

   Overall levels of payments are not dependent on the payment method. Some payment methods are, however, more responsive to changing case mix than other methods. Are the reimbursement parameters at a level where providers will have adequate resources including staffing, wage levels, benefit levels, and physical plant maintenance to meet expectations of consumers?

5. **Promote quality care for beneficiaries**

   Almost no payment method in the U.S. specifically and substantially rewards quality. However, experimentation with paying for quality is now under way across the country. Listing quality as a separate criterion reminds us that payment may well reflect quality differences in the future. Any measure should not be punitive but should reward exceptional quality. Impacting direct staffing impacts quality.

6. **Timely recognition of changing costs; especially those targeted to improve resident care**

   Consider the flexibility of the payment method in recognizing increased costs for resident care.

7. **Fairness in payments across facilities**

   The primary test is whether different facilities are paid similar amounts for similar care, with the key question being what we mean by "similar care." A secondary test is whether differences in payments by facility reflect differences in costs truly beyond a facility's control, such as prevailing wage levels in the local area.

8. **Efficiency and ease of administration - Nursing facilities**

   For providers, administrative ease is related to simplicity and familiarity. This criterion also looks at how nursing facilities are likely to be impacted by a particular payment method change.

9. **Efficiency and ease in administration - DOM**

   Except for paying a straight percentage of charges, no payment method is truly easy to administer or maintain for Medicaid. However, administrative ease can be better or worse

10. **Purchasing clarity for the State (DOM)**

    Does the payment method help DOM know what it is purchasing? Knowledgeable buyers are wise buyers, but the complexity of billing practices and payment methods often obscures just what is being purchased and how well the various facilities provide it.

11. **Insure appropriate access to capital markets**

    The payment method will provide resources so that facilities can renovate and if necessary replace physical plant and obtain the financing necessary.

12. **Keep the nursing facility program affordable for Medicaid, and for the taxpayers of Mississippi**

    To what extent does a payment method give DOM control over total payments? Does it enable DOM to make accurate forecasts of future spending? Does the payment method encourage efficiency and economy in the program?

13. **Assure the appropriate level of care for Medicaid beneficiaries**

    By recognizing and rewarding services to more acute residents, this criterion measures how well a payment method recognizes and rewards facilities for placement of higher acuity residents.

Each potential payment method change will be graded on how well it meets each goal. Grading will be done on a traditional scale of A, B, C, D and F. All grades are relative. That is, for any goal, if one method receives a grade of B and another a grade of C, it simply means that the workgroup believes that the first method does a slightly better job of meeting that particular goal. In the final report to the Legislature, the grades for each potential method will be summarized using the report card approach presented in the following table:

| Goal | RUG III | RUG IV | Cost Based | Price Based | Facility Based | Patient Based | All Facility CMI | Medicaid CMI |
|---|---|---|---|---|---|---|---|---|
| **Tier One Goals** | | | | | | | | |
| Maintain access to care | | | | | | | | |
| Stability and predictability in revenue | | | | | | | | |
| Provide adequate resources-regulatory expectations | | | | | | | | |
| Provide adequate resources-consumer expectations | | | | | | | | |
| **Tier Two Goals** | | | | | | | | |
| Quality care | | | | | | | | |
| Timely recognition of changing costs | | | | | | | | |
| Fairness across facilities | | | | | | | | |
| Ease of administration-nursing facilities | | | | | | | | |
| Ease of administration- DOM | | | | | | | | |
| **Tier Three Goals** | | | | | | | | |
| Purchasing clarity | | | | | | | | |
| Access to capital markets | | | | | | | | |
| Affordable for Medicaid and taxpayers | | | | | | | | |
| Assure appropriate level of care (setting) | | | | | | | | |

### 4.3. Options for transitioning to a new method

Depending on the impact of the recommended changes to the payment method, a transition plan may be developed for consideration. A transition plan could include a phased approach to changes, policy adjustors to mitigate severe impacts, or other mechanisms to assure a smooth transition to a revised payment method.

# 5 Feasibility of Payment Provisions that Encourage Quality Care

The classic approach to quality measurement considers:

- Structure (e.g. nursing staff ratios)
- Process (e.g. the percentage of residents who received appropriate immunizations)

- Outcomes (e.g. percentage of residents who develop pressure ulcers)

In the nursing facility industry we can add measurement of customer satisfaction to that list.

If Mississippi decides to begin collecting and analyzing data on quality measures, that data may be used to design a Pay for Performance (P4P) component to the nursing facility rate. However, it is also possible to influence quality simply through the process of collecting and reporting on facility performance related to specific quality goals.

The typical P4P component is an add-on to the facility rate, based on exceptional performance relative to pre-determined goals. Setting up the performance measurement program requires a great deal of preparation and data gathering, in order to establish the current baseline as well as to set targets for improvement. DOM must identify adequate resources to gather and analyze quality data on an ongoing basis.

The Quality subgroup of the nursing facility workgroup is actively investigating the question of quality measurement and P4P. Recommendations will be included in the final assessment report.

# 6 Status Report

The Division of Medicaid is actively working with the nursing facility industry to evaluate potential changes to the nursing facility payment method. The final assessment of those potential changes, along with specific recommendations for changes to the payment method is scheduled to be complete in the first quarter of 2013.

The effective date of any recommended changes will be dependent on the extent and type of changes recommended. A timeline will be included with the final report.

# 7 Legislative Recommendations

Specific legislative recommendations will be included with the final report.

**Notes:**

1. Kevin Quinn and Martin Kitchener, *Medicaid's Role in the Many Markets for Health Care*, Health Care Financing Review/Summer 2007/Volume 28, No.4.
2. Harrington, Carillo, Blank and O'Brian (*Nursing Facilities, Staffing, Residents and Facility Deficiencies*, 2005-2010); Department of Social and Behavioral Sciences, University of California San Francisco, September 2011.
3. Data compiled from Kaiser Foundation, *State Health Facts* 2010 http://www.statehealthfacts.org

# Appendix A - Workgroup

Nursing Facility Reimbursement Methodology Revision Committee Members:

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- Margaret King
- Robert Carter
- Eric Everett
- Louanne Holman
- Patricia Holton
- Evelyn Silas
- Brian Smith
- T.J. Walker

Xerox State Healthcare
- Kathleen Martin
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Mississippi Department of Health
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- Brian Cain, Owner
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Mississippi Healthcare Association
- Bobby Beebe, Facility Manager
- Harold Beebe, Owner
- Bobby Rotolo, Owner
- Joe Lubarsky, Consultant
- Shane Hariel, Cost Report Preparer @Horne, LLP
- Margaret Leverette, Case Mix Nurse
- Tammy Martin, Administrator of West Point Community Living Center
- Diane Platt, Administrator of Cedars Health Center
- Stan Maynard, Methodist Senior Services
- John Reed, Shearer Richardson Nursing Facility
- Gary Gardner, CFO at Community Eldercare

Mississippi Healthcare Association (cont.)
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- Margaret Stept, Administrator of the Millcreek facilities
- J.W. Stewart, Cost Report Preparer at the Millcreek facilities
- Charles Shearer, Son Valley
- Dan Estes, Covenant Dove

Attendees not affiliated with an association
- Todd Jones, Administrator of Oak Grove Nursing Home
- Thomas Kuluz, CFO at Corporate Management
- Paul Black, CFO at Winston Medical Center
- Aubrey Holder, CPA at Watkins, Ward & Stafford
- Danny Lamier, Alexander Milne Home for Women
- Jay Massey, Cognos Consultants
- David Stewart, Stewart & Barnett

Attendees, but not committee members
- David Dzielak, Executive Director of Division of Medicaid
- Richard Roberson, Division of Medicaid
- Will Crump, Division of Medicaid
- Douglas Stewart, Executive Account Manager of Xerox State Healthcare
- Alice Mitchell, Executive Director of Independent Nursing Home Association
- Vanessa Phipps Henderson, Executive Director of Mississippi Healthcare Association
- Melzana Fuller, Mississippi Healthcare Association
- Karyn Thornhill, Inzinna Consulting

# Appendix B – Payment Method Options

**Case Mix Reimbursement System**

Resource Utilization Groups (RUGs-III) is a case mix system which sets payment based on the resources expected to be used to care for a resident based on the functional support requirement and medical needs of each resident. There are thirty-four (34) groups used in the Mississippi Medicaid Case Mix Program plus a default classification when assessments are unable to be classified.

- *Resource*—staff resources are what the system pays for. Staff resources include nursing and rehabilitation/specialized therapy services.
- *Utilization* is how much resource (staff time) is used to care for residents. (Staff Time Measurement studies were conducted to actually associate the direct time staff spent with residents, time spent on behalf of residents, and other time associated with the operation of the nursing facility.)
- *Groups*—determined through analysis of data which identified residents with similar characteristics using similar resources.

**Choice of Resource Utilization Grouper (RUG) to calculate case mix: RUG III or RUG IV**

DOM currently uses the RUG III grouper to calculate the facility case mix index (CMI), which is used to adjust the Direct Care (nursing care) portion of each facility's rate. RUG III uses certain data elements from the resident assessments (MDS) completed by the nursing facilities to assign a category describing each resident's use of nursing resources. The RUG III grouper has been in use for several years. It assigns each resident to one of 35 categories, depending on resident specific characteristics. The RUG III grouper was designed for use with the previous version of the MDS record, MDS 2.0. However, DOM has adapted the program to extract the information it needs for grouping from the current version of the MDS record, MDS 3.0.

The RUG IV grouper is an updated version of the grouper, available since October 2010. This grouper uses the same assessments to determine a RUG category, but it uses more information from the assessment, and it has more discrete options for categories. The RUG IV grouper assigns each resident to one of 48 categories, depending on resident specific characteristics. The RUG IV grouper was designed for use with the current version of the MDS record, MDS 3.0.

Both groupers are in the public domain. Both groupers use a set of relative weights to describe the relative acuity of residents in each category. DOM has adapted the weights for RUG III to be Mississippi specific. The same could be done with the RUG IV grouper weights.

**Cost based rates vs. price based rates**

Currently, Mississippi nursing facility rates are cost based. Cost based rates are set for each facility based on facility prepared and submitted cost reports and are rebased periodically based on updated cost report information. The cost based rate would typically include a feature that would adjust the Direct Care component of the rate for case mix (either facility wide or resident specific). This method puts the majority of the risk for increased cost on the State. Facilities have limited risk when incurring additional costs, because they can pass most of the new cost through to the

State. There are some limits on various costs that Medicaid will accept, which keeps only a small amount of the risk on the facilities.

Price based rates can be facility specific, based on peer groups, or statewide. With price based rates, Medicaid agrees to pay a certain price for nursing facility services. The price based rate would typically include a feature that would adjust the Direct Care component of the rate for case mix (either facility wide or resident specific). The larger the group that shares a price based rate, the more the risk shifts to the industry and away from the State, assuming that the initial price is based on the collective cost of the group. If, for example a peer group price is set, based on the average cost of the facilities in the peer group, each facility, then, is under some constraint to conform their operating costs to the average of the group in order to function within the price.

**Facility rates vs. resident specific rates**

Resident specific rates: rates that relate to the identified needs of the particular resident

Facility based rates: rates that represent the average of all residents in a facility

Nursing facilities in Mississippi are currently paid a facility based rate, based on average cost and case mix for their facility. (See section 3.1, above, for a more complete description of the current rate method.)

It is now possible to pay nursing facilities a separate rate for each resident, depending on the RUG category of the resident. This is very similar to how Mississippi hospitals are now being paid, where each resident stay is assigned a DRG which determines the total payment. In the case of nursing facilities, there could be a base rate for each facility, which would be adjusted for the acuity of each resident when claims are paid. This option would require changes to the claims payment system.

Resident specific rates have the advantage of giving the facility an immediate change in rate when the resident acuity changes (as determined by a new MDS/RUG). With facility based rates, the impact of the change in acuity does not affect the facility rate for several months.

**Use of the Medicaid case mix index in rate-setting**

DOM currently calculates only the facility wide case mix for each facility. Case mix is based on the relative weights of the RUG categories assigned by the RUG grouper. The facility wide case mix describes the overall acuity of all residents in the facility, relative to a statewide average. This case mix value is used to adjust the Direct Care (nursing care) portion of each facility's rate.

In order to understand the relative cost of Medicaid residents, the Medicaid case mix would have to be calculated. Typically (but not universally), Medicaid residents are lower acuity than the overall nursing facility population. The main reason is that the overall case mix includes short-term, high acuity Medicare residents, which usually makes the all-facility case mix number higher than the Medicaid-only case mix number. As a result, Medicaid is currently paying a per diem cost that does not accurately reflect the true cost of caring for Medicaid residents, but is generally higher.

Most states that adjust nursing facility rates for case mix utilize the Medicaid case mix. The question of case mix adjustment is only relevant if facility based rates are used. If the decision is made to move to resident specific rates, the case mix adjustment is applied at the resident level, specific to that resident, so it is not necessary to calculate a facility average.

# Recommendation for Pharmacy Reimbursement Methodology Change in Response to House Bill 421

**Mississippi Division of Medicaid**

October 2012

# Executive Summary

## Purpose

Section 5 of House Bill 421 directs the Mississippi Division of Medicaid (DOM) to *"develop a plan providing revisions to the current reimbursement methodology for prescription drugs… including necessary legislative recommendations. The Division will not implement these plans, but shall submit the plans to the Public Health and Welfare Committee of the Senate and the Medicaid Committee of the House no later than October 15, 2012."* This document constitutes the Division's report in compliance with the legislative direction. This report also contains the methods, results and recommendations from a cost of dispensing study and an acquisition cost survey of Mississippi pharmacy providers.

## Overview

Mississippi's Medicaid pharmacy reimbursement methodology currently incorporates the Average Wholesale Price (AWP) benchmark for brand and generic drugs. AWP is a national pharmaceutical pricing benchmark that has been used in pharmacy reimbursement for over 40 years and is based on drug manufacturer-reported information that is compiled by drug pricing compendia. AWP is intended to represent the average price that wholesalers sell drugs to pharmacy providers and is often thought of as the "sticker price" for the cost of pharmaceuticals purchased by pharmacy providers. However, evidence consistently finds that the AWP benchmark is inaccurate and grossly overstated in many cases. The effect of using this inflated benchmark often resulted in overpayment to pharmacies by State Medicaid agencies and thus increasing Medicaid costs to MS taxpayers. Litigation regarding over-inflation of AWP resulted in one of the major compendia discontinuing publication of AWP in late 2011.[1]

Despite questions regarding the validity of the AWP as a pricing benchmark, there has not been a clear replacement that has been widely implemented in pharmacy reimbursement. Currently available alternatives to AWP include Average Acquisition Cost (AAC), Wholesale Acquisition Cost (WAC), Average Sales Price (ASP), and Direct Price (DP). Each of these methods has strengths and limitations as pricing benchmarks that will be discussed further in this report.

Medicaid is one of the largest purchasers of prescription drugs. The Kaiser Family Foundation reported that Medicaid paid approximately $25 billion to pharmacies for drugs in 2009. This is reported to be 10 percent of the total US prescription market.[2] With rising drug costs, there is even more pressure on State and Federal agencies to control this spending.

Centers for Medicare and Medicaid Services (CMS) issued a proposed rule change in February 2012 that presents several major changes to state Medicaid pharmacy reimbursement policy. One of the major changes is a replacement of drug ingredient reimbursement terminology used. CMS proposed to replace the term

[1] New England Carpenters Health Fund Settlement. Accessed from http://www.gpo.gov/fdsys/pkg/USCOURTS-mad-1_05-cv-11148/pdf/USCOURTS-mad-1_05-cv-11148-0.pdf on 9/2011.

[2] Kaiser Commission on Medicaid and the Uninsured. Managing Medicaid Pharmacy Benefits: Current Issues and Options. September 2011.

"estimated acquisition cost" with "actual acquisition cost (AAC)" as "changing this definition for the drug ingredient component of the reimbursement formula to AAC will be more reflective of actual prices paid, as opposed to estimates based on unreliable published compendia pricing."[3] This fundamentally changes the approach by which state Medicaid agencies must address drug ingredient reimbursement. Once this rule is finalized, State Medicaid agencies will need to be prepared to implement these changes.

The goal of the Division is to provide accurate, reflective, and reasonable reimbursement to pharmacy providers that will allow for maintained access to prescription services for Mississippi Medicaid beneficiaries. The Division also takes seriously our responsibility to be good stewards of tax payer money and effectively manage the pharmacy program within budgetary constraints. These goals can only be realized if pharmacy reimbursement is based on a pricing benchmark that is aligned with drug acquisition and dispensing costs that Mississippi pharmacy providers truly experience.

## Pharmacy Reimbursement

There are two primary components to pharmacy reimbursement for a drug, *ingredient cost* and a *dispensing fee*. These two costs are summed to the total pharmacy reimbursement that a pharmacy provider would receive pursuant to dispensing a prescription and both must be considered.

### Ingredient Reimbursement

Ingredient cost reimbursement is paid to pharmacy providers to reimburse for the cost of the drugs used to fill prescriptions. The State of Mississippi currently reimburses ingredient costs for Medicaid participants on an AWP-based methodology. The Office of the Inspector General (OIG) has consistently found that AWP-based reimbursement has become inaccurate and has caused Medicaid agencies and the federal government to pay too much for drugs.[4] Refer to section E on page 11 for DOM's pharmacy reimbursement details.

### Dispensing Fee

In addition to the drug ingredient reimbursement, pharmacy reimbursement for drug claims involves the payment of a dispensing fee. A dispensing fee compensates pharmacy providers for transferring the drug from the pharmacy to the patient and includes the cost of labor, supplies, delivery and overhead. Mississippi's current Medicaid dispensing fee is $3.91 when dispensing a prescribed brand name medication or over-the-counter product and $4.91 when dispensing a prescribed generic medication. A cost of dispensing study was performed in Mississippi in October 2011. The statewide average cost of dispensing, weighted by Medicaid volume, was $10.65 per prescription. The information collected indicates that the DOM currently reimburses well above acquisition costs for ingredient reimbursement and below the provider's true cost to dispense. In order to follow the guidelines within the CMS proposed rule, States must closely align ingredient reimbursement with actual acquisition cost experiences of providers. The cost of dispensing must also be evaluated to ensure that pharmacies are reimbursed appropriately for the dispensing fee component. This approach would create a reimbursement methodology that is more accurate, reasonable and transparent to both the State and pharmacy providers.

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[3] *Federal Register Volume 77, Number 22 (Thursday, February 2, 2012)*

[4] "Replacing Average Wholesale Price: Medicaid Drug Payment Policy." Office of Inspector General. July 2011.

## Surveys

The Division engaged Myers and Stauffer LC, a national certified public accounting firm, to perform a cost of dispensing study and an acquisition cost survey of Medicaid participating Mississippi pharmacy providers. Myers and Stauffer LC has worked with State Medicaid agencies in more than 35 states as well as the federal government and has also worked with the Mississippi Medicaid pharmacy program since early 2008. Myers and Stauffer LC are pioneers of acquisition cost-based pharmacy reimbursement and have conducted pharmacy drug acquisition cost surveys in multiple states for over a decade. They continue to work with states to develop, implement and manage these programs. CMS has recently contracted with Myers and Stauffer to develop a National Pricing Benchmark that is based on acquisition cost methodology used in the State programs they currently manage.

### Cost of dispensing

The dispensing study followed the methodology and used a survey instrument similar to those used by Myers and Stauffer in Medicaid pharmacy engagements in several other states. The study was initiated in September 2011. The 819 in-state pharmacies were requested to submit survey information for the study. Of these providers, 349 or 43% of pharmacy providers submitted usable data that was included in the analysis.

### Acquisition Cost Survey

The acquisition cost survey followed the methodology used in several other states. The study was performed in July 2012. Mailings were sent to 824 in-state Medicaid participating pharmacies requesting actual acquisition cost information. Of the surveyed providers, 189 or 23% of pharmacy providers submitted usable data that was included in the analysis.

## Summary of Findings

Fiscal analyses were performed using the data collected from the cost of dispensing and AAC studies. Savings and expenses reported are combined State and Federal dollars. State share of expense and savings are calculated using the Federal Medical Assistance Percentage (FMAP) which CMS reports as 73.43 for FY 2013.[5] Analyses show a combined State and Federal projected drug ingredient cost and dispensing fee reimbursement savings of $34.3 million (State share $9.1 million) using data from paid claims submitted from July 2011 through June 2012. This figure combines the projected $25.9 million cost of increasing the dispensing fee and the projected $60.2 million drug ingredient cost savings using average acquisition cost methodology (see appendix for more detail). This demonstrates the overall program cost savings attributed to an AAC-based pharmacy reimbursement methodology and an updated cost of dispensing based on a cost of dispensing study.

To further explain the cost savings, we compared the average reimbursement per prescription that is paid to pharmacy providers by Mississippi and Alabama Medicaid programs. Alabama was the first State to reimburse brand and generic pharmacy products with an AAC-based methodology and serves as a good comparator for average prescription spend for programs utilizing an AAC-based approach. Examining Mississippi and Alabama paid pharmacy claims from a recent 12 month period showed that Mississippi paid an average of $245 per brand

[5] Federal Register Volume 76, Number 230 (November 30, 2011)

name prescription and $31.35 for each generic prescription. Alabama paid an average of $234 per brand prescription and $23.13 per generic prescription. Mississippi paid an average of $11 more for each brand name prescription and $8 more for each generic prescription.

Drug utilization reports available on CMS's website show that in FFY 2010 Mississippi ranks 37th out of the 39 States in average generic spend per prescription (Appendix B).[6] This number is reported by State Medicaid agencies through the Medicaid Drug Utilization Review Annual Report Survey. The reporting period of this data is October 2009 through September 2010, prior to Alabama's AAC-based methodology transition. This data suggests that Mississippi is among the least efficient payers of generic prescriptions and has considerable room for improvement.

Mississippi fills prescriptions with generic medications approximately 70% of the time and this number can continue to grow with the number of generic medications losing patent exclusivity and generic medications becoming available in the marketplace. The Division has worked to reduce program costs by increasing generic medication utilization by placing policy limits on brand name medications and also limiting brand name medications to cases where a generic alternative does not exist or there are clear clinical reasons for dispensing the brand name product. The Division has decreased pharmacy program costs with implementation of a Preferred Drug List with associated supplemental rebates. In some situations, the preferred branded drug is less expensive to the state than the generic and/or therapeutic equivalent and the generic drug(s) is/are non-preferred. Providing tighter control over generic reimbursement and aligning reimbursement with acquisition costs will further the efforts of program cost containment and will align reimbursement with ingredient and dispensing fee costs that are truly realized by Mississippi pharmacy providers.

## Cost Consideration

In other state programs, the shift from AWP-based reimbursement to average acquisition cost based reimbursement resulted in significant ingredient cost savings. These savings far exceeded the costs associated with operating the program. The level of savings is determined by program policy and baseline reimbursement. The Division anticipates that the dispensing fee would need to be increased from the current rates to an amount that approximates the results of the cost of dispensing study. If the dispensing fee is increased, savings from the ingredient cost portion of reimbursement would more than offset the additional dispensing fee cost.

Combined fiscal analysis of the drug ingredient cost and dispensing fee surveys show an annual projected State and Federal program savings of $34.3 million (State savings $9.1 million). This does not include the cost of AAC program maintenance or necessary system programming changes that would be required to implement an AAC-based approach.

As with other types of programmatic changes, there are routine expenses for the ongoing management, maintenance and upkeep of the program. These expenses are quite minimal compared to the projected savings estimates provided above.

[6] CMS 2010 Drug Utilization Review Reports. Available at www.medicaid.gov.

## Recommendation

With considerations of the options available to the state at the time of this writing, the Division recommends replacing the current AWP-based reimbursement methodology with an AAC-based reimbursement methodology.

With the recommended change in reimbursement, the Division also recommends an increase to the dispensing fee that reflects the cost of dispensing outlined in the Survey of the Average Cost of Filling a Medicaid Prescription in the State of Mississippi that was performed in October 2011. This would replace the current dispensing fee of $3.91 for prescribed brand named medications and over-the-counter products and $4.91 for prescribed generic medications that is currently in place with a $10.65 dispensing fee for all medications dispensed.

AAC programs are most effective when the rates are updated often to reflect drug market price changes. It is also important to have an avenue for provider's inquiries regarding pricing concerns. States that currently have AAC programs utilize a pharmacy help desk operated by Myers and Stauffer LC. The help desk, staffed by pharmacy technicians, offers open access to pharmacy providers for prompt resolution of pricing questions or concerns. Most calls received by the pharmacy help desk are returned within 24 hours with resolution of the call in 48 hours. Each call is investigated and those cost observations that are found to represent true pricing changes may be eligible for adjustment. The help desk will have ongoing communication with the provider to let them know the status of their inquiry.

Through the recommendation to use AAC-based reimbursement, the Division seeks to shift pharmacy reimbursement to a transparent methodology that provides the best estimate of drug acquisition prices paid by providers. The use of the AAC for determining reimbursement rates meets this goal. The strengths of this approach over other available benchmarks include transparency of the rate-setting process, freedom from rates manipulated by manufacturers, reliance on actual drug costs based on invoices, and timely establishment of rates.

# House Bill 421 Required Report

# Plan To Revise Current Reimbursement Methodology for Prescription Drugs

## A. Introduction

Section 5 of House Bill 421 directs the Division to develop a plan for providing revisions to the current reimbursement methodology for prescription drugs including necessary legislative recommendations. The Division will not implement these plans, but shall submit the plans to the Public Health and Welfare Committee of the Senate and the Medicaid Committee of the House no later than October 15, 2012. This document constitutes the Division's report in compliance with the legislative direction.

## B. Background

State Medicaid drug reimbursement is defined by both Federal and State regulations. The federal law obligates state Medicaid programs to pay a reasonable value for the cost of a drug as well as a reasonable fee for the pharmacists' time and effort in filling a prescription.[7] Federal Medicaid regulations further define this "reasonable value" obligation by mandating that Medicaid programs reimburse pharmacies based on an Estimated Acquisition Cost (EAC) of the pharmaceuticals.[8] The regulations go on to define EAC as "the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers." In addition, federal regulations require Medicaid programs to apply "a reasonable dispensing fee established by the agency."[9] States are required to define their process for calculating EAC and dispensing fees in their State Plan that is submitted for CMS approval. Refer to section E on page 11 for DOM's pharmacy reimbursement details.

## C. CMS Guidance

Centers for Medicare & Medicaid Services (CMS) has proposed the following changes to the Code of Federal Regulations that pertain to State Medicaid Reimbursement Methodology. The following excerpts are from the Federal Register posted in February 2012;

> *"…We believe it is necessary for States to have a more accurate reference price to base reimbursement for prescription drugs. Therefore, we propose to replace the term, ''estimated acquisition cost'' with ''actual acquisition cost'' (AAC). We believe that changing this definition for the drug ingredient component of the reimbursement formula to AAC will be more reflective of actual prices paid, as opposed to estimates based on unreliable published compendia pricing."*[10]

This excerpt from the Federal Register provides the States with CMS guidance on pharmacy reimbursement and demonstrates a fundamental change in ingredient reimbursement methodology. The purpose of the proposed change is to better align pharmacy ingredient reimbursement with actual acquisition costs paid by providers, and become less dependent on the available pricing benchmarks which have proven to be unreliable in reimbursement formulas. Coupled with the proposed changes in ingredient cost, CMS also is proposing changing the terminology of dispensing fee to "professional dispensing fee", which represents the professional services and costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. Below is an additional excerpt from the Federal Register;

> *"…Therefore, as States change their payment for ingredient cost, we also propose to require States to reconsider the dispensing fee methodology consistent with the revised requirements."*[11]

[7] *U.S.C. §§ 1396(a)(23),(32)*
[8] *42 C.F.R. § 447.301*
[9] *42 C.F.R. § 447.332*
[10] *Federal Register Volume 77, Number 22 (Thursday, February 2, 2012)*
[11] *Federal Register Volume 77, Number 22 (Thursday, February 2, 2012)*

As ingredient reimbursement becomes more reflective of actual costs paid by providers, dispensing fees will also have to be closely examined to ensure adequate provider reimbursement for the professional services they provide.

To fulfill the current obligation of providing the best estimate of drug prices paid by providers, and to comply with the reimbursement changes proposed by CMS, AWP should be replaced as one of the benchmarks upon which reimbursement methodology is based. The replacement option should be reflective of costs actually paid by pharmacies for drugs and should also be transparent to reduce susceptibility to the manipulation that affected the AWP. The benchmark must be updated in a timely manner and accessible to the State. Using actual cost observations from Mississippi providers to establish a pricing benchmark for pharmacy reimbursement will accomplish these goals.

## D. Pricing Benchmarks

There is an array of published benchmarks measuring the price of pharmaceuticals at various points in the pharmaceutical delivery chain. Each benchmark has its own strengths and weaknesses. The following is a brief description of the major benchmarks used in pharmaceutical pricing.

*i. Average Wholesale Price ("AWP")*

Most State Medicaid programs have historically utilized a benchmark known as the "average wholesale price" or "AWP" in their pharmacy reimbursement methodology. Forty-five states were using AWP in their pharmacy reimbursement methodologies in first quarter 2011 as reported by The Office of Inspector General in their July 2011 report entitled *Replacing Average Wholesale Price: Medicaid Drug Payment Policy.*

First DataBank was one of the publishers of the AWP benchmark. As late as 2000, First DataBank reported that its AWP benchmark represented "the average of the prices charged by the national drug wholesalers for a given product."[12] However, evidence began to mount that the AWP benchmark was inaccurate and grossly overstated in many cases.

Following the resolution of a national class action brought against First DataBank related to published AWP prices, they decided to discontinue publishing the AWP benchmark in September 2011.[13] Another AWP benchmark publisher, Medi-Span, also considered discontinuing publication of the AWP but has since decided to continue publishing the benchmark at this time. Mississippi Medicaid currently continues to rely on the Medi-Span AWP for calculation of the EAC.

*ii. Wholesale Acquisition Cost ("WAC") also known as Wholesale Net Unit or (WNU)*

One of the other benchmarks often used in the industry is known as "Wholesale Acquisition Cost" or "WAC," which is defined in the federal statute as "the manufacturer's list price for the drug or biological to wholesalers

[12] *In re Pharmaceutical Industry Average Wholesale Price Litigation*, 230 F.R.D. 61, 68 (D. Mass. 2005).
[13] Department of Health and Human Services, Office of Inspector General: *Replacing Average Wholesale Price: Medicaid Drug Payment Policy* at p. i (July 2011).

or direct purchasers in the US, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data".[14] One study showed that for brand-name, self-administered drugs, the relationship between WAC pricing and AWP pricing has shown that the AWP price was 20% to 25% above the WAC price. For generic drugs, the relationship is less established, "with AWPs sometimes reaching 50% to 100% above WAC."[15]

There is not a current legal requirement forcing manufacturers to publish WAC pricing. Most brand drugs have a WAC reported by the manufacturer, however many generic medications do not. WAC is not a transparent pricing benchmark as it is reported directly by the drug manufacturers and there is not a standard process among manufacturers to determine how this index is calculated. Because of this it may be susceptible to the same pricing inflation that afflicted the AWP. Despite its limitations, WAC could potentially serve as a pricing "backup" in an acquisition cost-based methodology. States that have transitioned to an AAC reimbursement methodology have used WAC-based pricing for drugs that do not have an AAC rate such as new drugs or lowly utilized drugs that have not had adequate cost observations to calculate a reliable AAC rate.

*iii. Average Acquisition Cost ("AAC")*

AAC represents the average amount paid by pharmacies to suppliers (e.g., wholesalers, manufacturers) for brand and generic drugs. Medicaid agencies calculate AACs by obtaining drug acquisition invoices from participating Medicaid pharmacies. Such invoice surveys require minimal administrative effort and can be completed by non-pharmacist personnel. Because AAC comes directly from provider purchase records it is reflective of drug costs, transparent and resistant to manipulation. The AAC rates would also be accessible to the State and timely making AAC ideal for use in reimbursement methodology and best accomplishes the obligations imposed on the state by federal law. Four other Medicaid programs - Alabama, Oregon, Idaho and Louisiana - currently use AAC-based reimbursement methodologies for brand and generic drugs. Other States are in development of an AAC approach as well and include Iowa, California and New York. CMS has also been working to develop a national acquisition cost based pricing benchmark that will be available to the States for reference.

iv. National Average Drug Acquisition Cost ("NADAC")

The National Average Drug Acquisition Cost ("NADAC") is a national pricing benchmark in development with CMS. The NADAC will be a reference file available for consideration by the States to assist with their individual pharmacy reimbursement policies. The NADAC derives from a national acquisition cost survey process of retail community pharmacies located in the fifty states and District of Columbia. Cost observations from pharmacy provider invoices are collected and analyzed for calculation of a national average acquisition cost. The reference file is planned to be available from the major drug pricing compendia. This pricing benchmark will have the

[14] Social Security Act. Section 1847A. Use of average sales price payment methodology. 42 USC § 1395w-3a, Section 303(c)6(B)

[15] *Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices." Office of Inspector General. June 2005.*

same benefits as the AAC, but may lack region or State specific characteristics. Once this benchmark is available, States will have the ability to compare this benchmark for potential use in reimbursement methodologies. Because NADAC is based on invoice costs, it will meet the goal of more closely aligning ingredient reimbursement with acquisition costs, but it is not yet known how this national value will compare to AAC values calculated at an individual State level.

*v. Federal Upper Limit ("FUL")*

To address overpayment of drugs by various state EAC formulas, in the mid-1980's CMS instituted the Federal Upper Limit ("FUL") program, in which CMS assigns the maximum allowable costs or "MAC" for "multiple source" drugs (generally, drugs with generic equivalents, both brand and the generic being subject to the FUL). The federal government's approach to establish FULs has changed over the years. Most recently, a provision of the Affordable Care Act mandates that CMS calculate FULs as no less than 175 percent of the weighted average of the most recent reported AMP. This new FUL calculation methodology has been the subject of intense scrutiny by pharmacy associations that have asserted the calculations place reimbursement below actual acquisition costs on more than half of the prescriptions filled by the pharmacies.[16] States can pay more than the FUL for a multiple source drug. However, under federal law, aggregate payments for all multiple source drugs may not exceed the aggregate FULs. This allows the Medicaid program to pay more than the FUL for some drugs as long as total amount reimbursed remains below the aggregate FUL for all drugs subject to federal limits. States use their state maximum allowable costs or SMAC program to monitor costs in order to be in compliance with CMS regarding aggregate FUL reimbursement.

*vi. State Maximum Allowable Cost ("SMAC")*

In addition to the other pricing constraints placed on pharmaceutical reimbursement, some states have also implemented an average acquisition cost-based State Maximum Allowable Cost ("SMAC") program to further control the reimbursement for generic drugs. The SMAC process typically involves collection of pharmacy invoices from a sample of state pharmacies, which are utilized in setting the SMAC rates. The SMAC rate for generic drugs is set at the average price paid for the generic drug adjusted by a multiplier to account for variations in purchasing power of the pharmacies.

*vii. Average Manufacturer Price ("AMP")*

For purposes of calculating manufacturer rebates owed to the federal and state governments, Congress mandated that all pharmaceutical manufacturers who participate in federally-funded health care programs must submit drug pricing information to the federal government.[17] One price point that manufacturers must submit is known as "average manufacturer price" or "AMP," which the statute defines as "the average price paid to the manufacturer for the drug in the United States" by either wholesalers for drugs distributed to retail community

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[16] *Michael Johnsen, NCPA: Latest FUL list from CMS a 'disaster in the making' (available at www.drugstorenews.com/article/ncpa-latest-ful-list-cms-disaster-making)*
[17] 42 U.S.C. § 1396r-8 (2011).

pharmacies, or retail community pharmacies that purchase drugs directly from the manufacturer. The pricing benchmark seeks to establish the "average price paid by wholesalers for drugs distributed to the retail class of trade, net of customary prompt pay discounts."[18] The AMP pricing information is based on actual sales transactions. Historically, AMPs are reported to the federal government for all Medicaid-covered drugs as a requirement of the Medicaid drug rebate program; most Medicaid programs do not receive the AMPs.[19] In accordance with section 1927(b)(3) of the Social Security Act (the "Act"), the Centers for Medicare and Medicaid Services ("CMS") began providing states in August 2011 with values concerning AMP and AMP Units in a file within the Drug Data Reporting for Medicaid System ("DDR"). The AMP and AMP Units are calculated on a monthly basis by drug manufacturers that participate in the Medicaid drug rebate program and are reported to CMS in accordance with the Act's requirements. Drug manufacturers certify the accuracy of AMPs in accordance with Federal regulations at 42 CFR 447.510(e). However, the AMPs have not been verified or audited by CMS. It is not clear whether there are limitations to the use of this data, such as confined only to use within the Drug Rebate program.

viii. Average Sales Price ("ASP")

Average sales price is calculated by CMS from manufacturer reported prices. It represents sales to all purchasers which would include wholesalers, warehouses and providers. One benefit of ASP is it is net of any price discounts making it representative of actual purchase prices. ASP is currently only available for drugs reimbursable by Medicare part B. Part B drugs are mostly injectable and inhaled drugs and make up only a very small share of the overall drug marketplace.

## E. Current Mississippi Medicaid Pharmacy Reimbursement

The Division currently reimburses pharmacy based on published AWP pricing. The following formulas are used;

*Brand Name Drugs (single source, innovator multiple-source and single-source generics)*

The provider is reimbursed the lesser of;

The provider's usual and customary charge (the charge to the general public); or

The EAC for brand name drugs which is defined as the lesser of:

AWP minus 12%, plus a dispensing fee of $3.91; or

WAC plus 9%, plus a dispensing fee of $3.91.

*Generic Drugs (multiple source)*

The provider is reimbursed the lesser of:

The provider's usual and customary charge (the charge to the general public); or

The EAC for multiple source drugs which is defined as the lesser of:

AWP minus 25%, plus a dispensing fee of $4.91 or

[18] Department of HHS, Office of Inspector General, *Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices* p. i (2005).

[19] "Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices." Office of Inspector General. June 2005.

The Federal Upper Limit, plus a dispensing fee of $4.91;

*dispensing fee is for LTC is $3.91 for all drugs

*Over the Counter (OTC) Drugs*

Reimbursement for covered non-prescription products or over-the-counter products is the lesser of:

The provider's usual and customary charge; or

The EAC for multiple source drugs which is defined as the lesser of:

AWP minus 25%, plus a dispensing fee of $3.91 or

Federal Upper Limit, plus a dispensing fee of $3.91.

WAC, plus a dispensing fee of $3.91

## F. Mississippi Pharmacy Stakeholder Involvement

In 2011 the Division held two stakeholder meetings to gather input and feedback of benefits and weaknesses of several pharmacy pricing benchmarks as a replacement to AWP-based methodology. The stakeholders included a pharmacy advisory group that was representative of Mississippi pharmacy providers including the Mississippi Pharmacists' Association (MPhA), Mississippi Independent Pharmacies Association (MIPA), as well as representatives from chain, independent and specialty pharmacies. There was consensus among the stakeholders that AWP was an unreliable benchmark and AAC was closer to what CMS envisions for ingredient reimbursement.

With consideration of the options available to the State, and the suggestions of the pharmacy stakeholders, there was general agreement that changes were forthcoming and inevitable. Stakeholders were made aware that "AWP" has become a flawed, unreliable and 'soon to be obsolete' pricing option. Stakeholders agreed that in addition to methodology changes for ingredient costs, there needed to be an updated dispensing fee. Myers and Stauffer reviewed options and outlined alternatives for stakeholders. The Division took the stakeholders suggestions under careful consideration and proceeded forward with the cost of dispensing study and the AAC survey process.

## G. Specialty Pharmacy

There is no consensus on a formal definition of specialty pharmacy or specialty drugs. Some characteristics which are commonly associated with the idea of a specialty pharmacy and specialty drugs include primary service of patients with chronic conditions that require high cost injectables, biotech, or other drugs requiring specialized oversight and care, drugs that require special handling or storage, and drugs that are available only through limited distribution channels (although some drugs that are considered specialty are available through traditional retail community pharmacies).

Specialty drugs are a rapidly growing segment of the pharmacy marketplace and represent an increasing percentage of pharmacy expenditures. Increased growth in the number of specialty drugs available in the marketplace as well as a wider distribution of these drugs are contributing to the growth of the specialty drug industry.

For purposes of this report, pharmacies that were considered to be specialty providers were included in the AAC and COD survey processes. However, limited participation from these providers restricts the ability to derive observations from their data.

## H. Survey Design and Results

### Cost of Dispensing Study

In July of 2011, The Mississippi Division of Medicaid contracted Myers and Stauffer LC to perform a cost of dispensing ("COD") study of Mississippi Medicaid pharmacy providers. The study methodology included mailing a cost survey instrument, instructions for the survey, a letter of explanation from the Division of Medicaid and a letter of explanation from Myers and Stauffer. These mailings were sent in September 2011 to the 819 in-state Mississippi pharmacy providers.

Pharmacy providers were given one month to complete the survey and submit for inclusion in the analyses. There were 354 usable survey results included into the final analysis. See Table 1 below for response demographics.

**Table 1. Cost of Dispensing Study Response Demographics**

| Pharmacy Category | Total Medicaid Enrolled Pharmacies | In-State Medicaid Enrolled Pharmacies | Pharmacies Exempt or Ineligible from Filing | Eligible Pharmacies | Usable Cost Surveys Received | Response Rate |
|---|---|---|---|---|---|---|
| Chain | 423 | 390 | 1 | 389 | 260 | 66.8% |
| Non-Chain | 493 | 429 | 12 | 417 | 94 | 22.5% |
| **Total** | **916** | **819** | **13** | **806** | **351** | **43.9%** |
| | | | | | | |
| Urban | 338 | 338 | 8 | 330 | 151 | 45.8% |
| Rural | 481 | 481 | 5 | 476 | 23 | 42.6% |
| Out of State | 97 | N/A | N/A | N/A | N/A | N/A |
| **Total** | **916** | **819** | **13** | **806** | **354** | **43.9%** |

The COD study utilizes cost finding procedures to isolate the costs involved in dispensing prescriptions to Medicaid recipients. To accomplish this objective, some pharmacy costs must be allocated between the prescription dispensing function and other business activities.

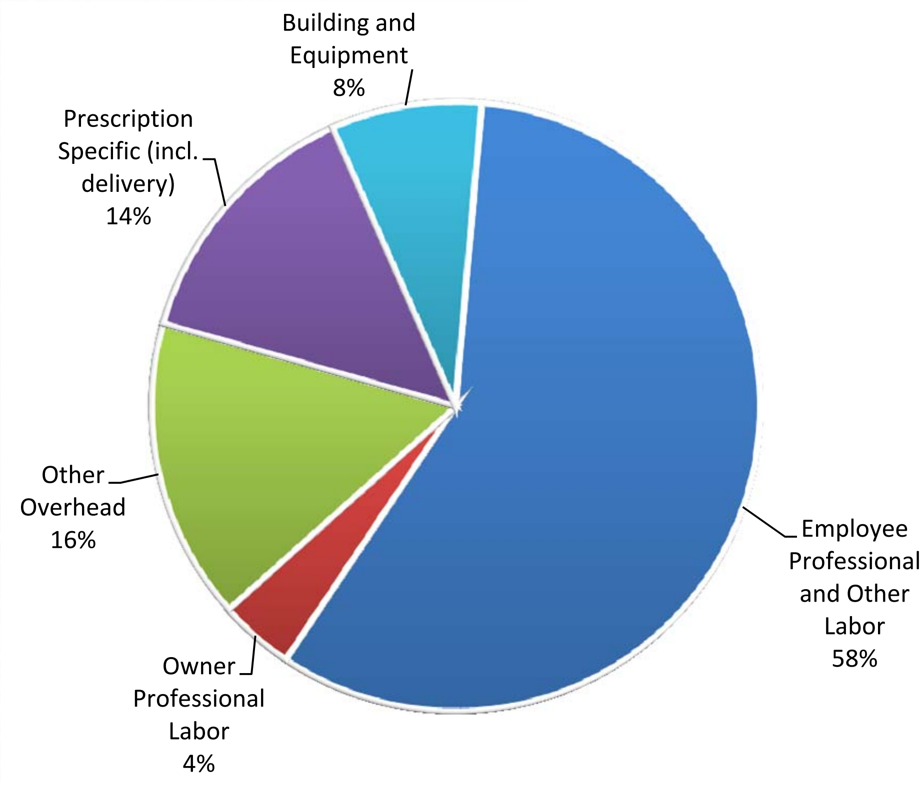
The two main components of dispensing costs are overhead and labor. Overhead costs include; prescription department licenses, delivery expenses, prescription computer expenses, prescription container and labels depreciation, real estate taxes, rent, repairs, utilities, personal property taxes, insurance, interest, accounting and legal fees, telephone, supplies, dues and publications and miscellaneous items identified on the survey tool. Notable overhead costs that were not allocated to the prescription department include income taxes, bad debts, advertising, and charitable contributions.

Labor costs are calculated by allocating total salaries, payroll taxes and benefits based on the percent of time spent in the prescription department. The allocations are summed and then divided by the number of prescriptions dispensed to calculate the labor cost per prescription. Table 2 and Figure 1 depict the components of the overhead cost as reported by the COD survey.

**Table 2. Components of Prescription Dispensing Cost**

| Type of Expense | Unweighted Average (Mean) Cost | Average (Mean) Weighted by Medicaid Volume |
|---|---|---|
| Owner Professional Labor | $0.614 | $0.385 |
| Employee Professional and Other Labor | $7.096 | $6.150 |
| Building and Equipment | $0.996 | $0.872 |
| Prescription Specific Expenses (incl. delivery) | $1.382 | $1.512 |
| Other Overhead Expenses | $1.690 | $1.734 |
| **Total** | **$11.778** | **$10.653** |

**Figure 1. Components of Dispensing Cost per Prescription.**




The statewide average of dispensing cost per prescription was $10.65 when weighted by Medicaid volume. This figure excludes five specialty pharmacies which exhibited a significantly different cost structure.

### Actual Acquisition Cost Survey

In July 2012, The Mississippi Division of Medicaid contracted Myers and Stauffer LC to perform an Average Acquisition Cost ("AAC") survey of Mississippi Medicaid pharmacy providers. The survey methodology included mailing a survey letter from the Division with background information, purpose of the survey, and instructions for completion of the survey process. After 14 days, providers that had not responded received a reminder notice from the Division that contained the same information as the initial letter. Pharmacy providers submitted 30 days of purchase documentation (invoices) to Myers and Stauffer for analyses. The survey included 824 Mississippi pharmacy providers. Myers and Stauffer received invoice information from 189 pharmacies yielding a 23% response rate. Table 3 below outlines the response rate based on pharmacy characteristics of urban or rural pharmacy locality and whether the pharmacy is a chain or an independently owned pharmacy.

**Table 3. AAC Survey Response Demographics**

| Pharmacy Category | Total Medicaid Enrolled Pharmacies | In-State Medicaid Enrolled Pharmacies | Pharmacies Exempt or Ineligible from Filing | Eligible Pharmacies | Usable AAC Surveys Received | Response Rate |
|---|---|---|---|---|---|---|
| Chain | 467 | 442 | 4 | 438 | 126 | 28.8% |
| Non-Chain | 452 | 382 | 0 | 382 | 63 | 16.5% |
| **Total** | **919** | **824** | **4** | **820** | **189** | **23%** |
| | | | | | | |
| Urban | 295 | 295 | 4 | 291 | 55 | 18.6% |
| Rural | 529 | 529 | 0 | 529 | 134 | 24.9% |
| Out of State | 95 | N/A | N/A | N/A | N/A | N/A |
| **Total** | **919** | **824** | **4** | **820** | **189** | **23%** |

Invoices were submitted to Myers and Stauffer by mail, email or fax. The invoices were tracked in a receipt log to ensure survey responses were counted. The submitted data went through multiple levels of review to ensure reasonableness prior to using in the analysis. Acquisition cost data that passed the preliminary reviews was compiled in a large cost database to be used in average cost calculations. After these calculations were completed, a final desk review for quality assurance was performed.

## I. Summary of Findings and Analysis

A thorough program analyses was performed using the data gathered from the cost of dispensing and AAC studies. These analyses include projected program savings with AAC-based reimbursement methodology, FUL analysis, and average spend per brand and generic prescriptions.

### Projected Program Savings

The cost of dispensing study found the statewide average (mean) cost of dispensing weighted by Medicaid volume was $10.65 per prescription. The current dispensing fee reimbursed by the State is $4.91 for generic medications and $3.91 for brand and over the counter medications. The projected fiscal impact of changing the dispensing fee reimbursement to the higher proposed figure would result in a projected annual increase in program expenditures of $25.9 million (Table 4). This projection is based upon Mississippi paid prescription claims from July 2011 through June of 2012.

**Table 4. Projected Annual Dispensing Fee Expenditures (Federal and State)**

| Claim Type | Current Dispensing Fee | Proposed Dispensing Fee | Claims | Est. Expends for Current Disp. Fees | Est. Expends for Proposed Disp. Fees | Difference |
|---|---|---|---|---|---|---|
| Brand Claims | 3.91 | 10.65 | 809,163 | 3,163,827.33 | 8,617,585.95 | (5,453,758.62) |
| Generic Claims | 4.91 | 10.65 | 3,105,975 | 15,250,337.25 | 33,078,633.75 | (17,828,296.50) |
| OTC Claims | 3.91 | 10.65 | 392,340 | 1,534,049.40 | 4,178,421.00 | (2,644,371.60) |
| **Totals** | | | **4,307,478** | **19,948,213.98** | **45,874,640.70** | **(25,926,426.72)** |

The average acquisition cost study found that there are significant program savings opportunities available from changing to an AAC-based methodology. The study compared the current AWP-based methodology to an AAC-based approach that uses the average acquisition cost of a drug as the basis for reimbursement. An AAC was calculated for drugs that account for 74% and 95% of the brand and generic spend respectively making it a thorough analyses of the drugs most commonly dispensed to Mississippi Medicaid enrollees. If a drug did not have an AAC calculated, the WAC was used in the analysis. Drugs that had neither an AAC nor a WAC were excluded from the analysis. Projected annual savings from brand name medication reimbursement was projected to be $11.5 million and savings from generic medication was projected to be $48.5 million. For reporting purposes over-the counter medications were analyzed separately. The projected fiscal savings for over the counter drugs was calculated to be $231,000. These numbers are summarized in Table 5. This level of ingredient savings is consistent with the ingredient savings realized in other states that have transitioned to an AAC-based ingredient reimbursement model. These projections are based upon Mississippi paid prescription claims from July 2011 through June of 2012.

**Table 5. Projected Annual Drug Reimbursement Savings (Federal and State)**

| Drug Type | Projected Annual Savings |
|---|---|
| Brand Medications | $11,507,421 |
| Generic Medications | $48,496,868 |
| Over-the-counter | $231,377 |
| **Total Projected Annual Savings** | **$60,235,666** |

Combining the projected dispensing fee program costs and projected ingredient program savings totals a net projected annual program savings of $38 million (Table 6). See Appendix A for an itemized savings report.

**Table 6. Projected Annual Fiscal Impact of AAC Based Reimbursement (Federal and State)**

| Reimbursement Type | Amount of Savings/Expense |
|---|---:|
| Drug Ingredient Cost (AAC reimbursement) | $60,235,666 |
| Dispensing Fee | ($25,926,427) |
| Program Savings | $34,309,239 |

### Federal Upper Limit (FUL) Analysis

The Federal Upper Limit is currently used by Mississippi in their generic drug reimbursement methodology. Generic drugs that have other pricing benchmarks higher than the FUL will be limited to payment at the FUL which acts as a price cap for these claims. States are required to meet the FUL aggregate test, meaning the total reimbursement for drugs that have an FUL must be below the total reimbursement if these same claims were paid using the FUL. Since an AAC-based program will reduce the cost of ingredient reimbursement, the State will have flexibility in how the FUL will be applied in the reimbursement methodology.

There are three options of how to use FUL in generic drug reimbursement methodology. The State may choose to continue using the FUL in generic reimbursement for all drug claims, eliminate the FUL from reimbursement methodology in its entirety or use the FUL in reimbursement but allow for some overrides to the FUL for situations when the FUL is below the AAC such as when market situations may influence higher acquisition costs. Each of these options has inherent risk of either provider dissatisfaction or the possibility that reimbursement would achieve levels higher than the FUL.

CMS has not provided official guidance on how States should use the FUL in reimbursement. To better understand the three options and how it would affect Mississippi Medicaid reimbursement, an FUL aggregate test was performed using the AAC rates from the acquisition cost survey. Generic drugs that either had an AAC or WAC as well as an FUL were included in this analysis. Projected drug utilization was taken from claims data for July 2011 through June 2012.

The analysis shows that pharmacy claims using the FUL as the only pricing rate (FUL aggregate) would have ingredient reimbursement of $42 million. The projected reimbursement using the AAC-based methodology, including limiting payment to the FUL when the FUL is lower than the AAC or WAC, shows a total ingredient reimbursement of $12 million. The proposed AAC rates contribute to much more savings than using the FUL alone as a price cap for ingredient reimbursement. The FUL aggregate was also compared to the AAC-based methodology without including the FUL in the reimbursement. In this scenario, reimbursement would not be limited to the FUL for drugs that have an AAC or WAC that is above the FUL. The analysis shows a total reimbursement of $13.7 million. These findings are summarized in Table 7.

**Table 7. FUL Aggregate Analysis**

| | AAC-based with FUL | AAC-based without FUL |
|---|---|---|
| FUL Aggregate | $42,034,874 | $42,034,874 |
| AAC Reimbursement | $12,021,247 | $13,718,350 |
| **Difference** | **$30,013,627** | **$28,316,524** |

The first option is to use the FUL in the reimbursement methodology for drugs that have an FUL and use it as a price cap for drugs that would have an AAC or WAC higher than the FUL. In this case the provider would possibly receive reimbursement less than the acquisition cost of the drug. This option has the least amount of risk of FUL aggregate test failure and consequentially losing Federal matching Medicaid dollars. This option would receive the highest amount of pharmacy provider dissatisfaction. The State would be limiting reimbursement to levels below what acquisition surveys show that providers are paying for the drug.

The second option is to eliminate FUL from the reimbursement methodology. This would ensure that providers were being paid at the average acquisition cost of the drug and not limit reimbursement when the FUL is lower than the AAC or WAC. This option carries the most risk of FUL aggregate failure and loss of Federal dollars since individual claims would not be limited to the FUL and there is no assurance or proactive mechanisms in place to monitor the frequency or magnitude of this option. However according to the FUL analysis, the risk of reimbursing more than the FUL in the aggregate using AAC-based reimbursement is quite small given the $28 million buffer.

The third option is to use FUL in generic reimbursement methodology, but allow the FUL to be overridden in specific circumstances. This would allow certain drugs to pay at the AAC or WAC instead of the lower FUL. This decision to override the FUL would be made after manual review. This review would look at such things as market availability, raw material shortages or recent published pricing increases that may reflect higher acquisition costs. This option is a blend of the first two options and carries less risk of FUL aggregate test failure than excluding FUL completely and also allows the providers to be reimbursed at the AAC for drugs that may have special circumstances leading to higher drug prices. This option could increase reimbursement as much as $1.7 million based on the FUL analysis. This figure comes from comparing the savings of using the FUL in the reimbursement methodology on every applicable drug and eliminating the FUL from the methodology.

The Affordable Care Act redefined the FUL to be calculated using an AMP based methodology. These FULs have not been used in reimbursement and currently are in draft format available for review through CMS. Many of the draft AMP-based FULs are lower than the current FULs and a repeat FUL analysis would be warranted to measure this effect. The Division will monitor this situation and ask for further CMS guidance as to how best apply FUL in reimbursement if the AMP-based FULs are used moving forward.

### Average per Prescription Spend

The total Medicaid reimbursement for each prescription is a combination of ingredient cost and a dispensing fee. Additional factors that are considered in total program cost are patient copay amounts and third party liability. To measure the Medicaid expenditure for each prescription dispensed, an analysis was performed that totaled the brand prescription reimbursement and the generic prescription reimbursement and then divided by the number of paid claims from July 2011 through June 2012 yielding the average Medicaid spend per brand and generic prescriptions. For this analysis, we held the patient copay and amount of third party liability constant to the current program. This analysis also did not consider drug rebates paid to CMS or the State by drug manufacturers. The results of this analysis show the average combined Federal and State amount of reimbursement paid to pharmacy providers for each individual claim.

Mississippi pays an average of $245.07 for each brand name prescription and $31.35 for each generic prescription. To measure the potential impact of AAC-based reimbursement methodology we compared to a current State AAC-based reimbursement program.

Alabama was the first state to utilize an AAC-based pharmacy reimbursement methodology for both brand and generic medications. Alabama achieved large program savings after AAC conversion and serves as an example of how tight Medicaid dollars can be used to compensate pharmacy providers in an accurate, transparent and reflective manner. We compared Alabama's AAC program to Mississippi's AWP-based approach. Alabama paid an average of $234.65 for each brand name medication and $23.13 for each generic medication. The disparity between the average prescription reimbursement is clearly seen in Table 8.

**Table 8. Average Spend per Prescription**

| State | Brand | Generic |
|---|---|---|
| Mississippi | $245.07 | $31.35 |
| Alabama | $234.65 | $23.13 |
| **Difference** | **$10.42** | **$8.22** |

### Provider Impact

The analyses clearly show that Mississippi providers are not currently reimbursed with a dispensing fee that is consistent with labor, overhead or ingredient costs that providers are experiencing. The relative underpayment on the dispensing fee side of reimbursement is not being felt by providers because of the relative overpayment of ingredient costs beyond their true acquisition cost. Therefore upward adjustment to the dispensing fee must be considered if ingredient cost reimbursement is transitioned to an acquisition cost based approach.

The AAC-based ingredient reimbursement will not cover the reported acquisition cost of some providers since by program design the "average" of the reported acquisition costs is used to set the reimbursement rate. Some providers will purchase drugs below the AAC and some providers will purchase drugs above the AAC. The AAC program will put pressure on providers that currently purchase many of their drugs above the AAC to purchase drugs more efficiently to move their acquisition costs closer to or below the average. This can be accomplished by more efficient purchasing, joining group purchasing organizations or renegotiations with wholesalers.

It is important to point out that pharmacy providers often receive “off-invoice” discounts such as prompt pay discounts, rebates, free goods and other credits from their wholesalers. These pricing discounts are not captured on the invoice and therefore are not considered in the AAC calculations. These savings will contribute to provider revenue and possibly profit for those providers that are purchasing drugs at or below the AAC rate. The Division does not seek to eliminate this type of provider compensation. Pharmacy providers will continue to be reimbursed with weekly checks making Mississippi one of the most timely and efficient payers among State Medicaid programs.

The Division would also like to encourage pharmacy providers to develop other professional services that utilize their cognitive skills and allow them to “work at the top of their licensure”. These services could include over the counter drug recommendations, medication therapy management (MTM) services, and vaccine administrations onsite at their pharmacy location. These services have potential for positive impacts and improved patient health outcomes for our enrollees. The Division hopes that with the added pressure of efficient purchasing of drugs, that pharmacy providers will seek other means of revenue growth. With Medicaid pharmacy program savings, the Division would like to see more investment in the growth of the services offered by Mississippi pharmacy providers and will work with stakeholders to explore these initiatives.

## J. Cost Considerations

Cost considerations for pharmacy reimbursement changes should include the proposed dispensing fee, projected ingredient cost, program maintenance, and system programming changes. Shifting from an AWP-based reimbursement to an AAC reimbursement has resulted in ingredient cost savings far above the AAC program operations cost in other states that have transitioned to this reimbursement approach. Fiscal analyses of drug and dispensing fee reimbursement show a projected combined Federal and State program savings of $34.3 million. The State share of this savings is $9.1 million. Cost of program maintenance and system program change are not insignificant but will only be a small percentage of the overall projected program savings.

Pharmacy providers will be reimbursed more from the increased dispensing fee but will see their ingredient reimbursement decrease to levels that align with true acquisition costs. The reimbursement will be reflective of the costs that they incur while providing prescription services to Mississippi Medicaid participants and the Division feels that this decrease in reimbursement is remedying overpayment by the State.

## K. Recommendations

Based upon the survey results and fiscal analyses, the Division recommends that the State replace the current AWP-based reimbursement with an AAC-based pharmacy reimbursement methodology and an updated dispensing fee that corresponds to the cost of dispensing survey. Also, the Division agrees with the National Association of Medicaid Directors and recommends the use of WAC pricing for drugs that do not have an AAC rate at the time of claim processing.[20] We feel that this is the most reflective, timely, transparent, economical and sustainable method of pharmacy reimbursement currently available to the State. The AAC approach has

[20] “Post AWP Pharmacy Pricing and Reimbursement.” The American Medicaid Pharmacy Administrators and The national Association of Medicaid Directors. November 2009.

proven to be cost effective and maintain pharmacy reimbursement at a level that will not compromise pharmacy access to Medicaid beneficiaries.

Two possible options for an AAC program are a State specific AAC program utilizing data gathered from Mississippi pharmacy providers through an AAC survey process, or utilizing the NADAC reference file. While the NADAC has promise to be a reliable national pricing benchmark, the State feels that at this time there has not been sufficient time to examine the NADAC to see if it would accomplish the goals of the Division. A State specific AAC program has shown through this analysis to be accurate and reflective of Mississippi provider costs and should be considered the best option at this time.

## Survey Frequency

### Cost of Dispensing

The Division recommends that the cost of dispensing survey be repeated every two to three years. The last survey was performed in October of 2011 and therefore a dispensing fee calculated from this survey data is considered valid at this time. With ingredient cost reimbursement becoming more tightly controlled, there will be pressure to ensure that the dispensing fee will be maintained and updated with rising overhead and labor costs.

Using inflation factors throughout the life of the cost of dispensing rate is a possibility; however CMS has not provided much guidance in this regard. The Division feels that repeating the COD study every two to three years will keep pace with the inflationary pressure of the dispensing costs of pharmacy providers. Repeating the cost of dispensing survey more frequently than that may cause undue provider burden with little change in the result of the survey.

### Average Acquisition Cost Survey

AAC programs are most effective when the rates are updated often to reflect drug market price changes. The Division recommends repeating the AAC survey process on a sample of Mississippi pharmacy providers semi-annually. The State does not feel that this will be overly burdensome to providers. The AAC survey process that was used for this analysis is reported to only take 30 minutes of non-pharmacist time to complete. In addition to the resurvey process, the AAC rates would have periodic updates based on changes in published pricing. We also recommend an avenue for pharmacy providers to be able to submit information to update rates based upon their purchase history. This can be accomplished by utilizing a pharmacy help desk to answer provider inquiries and propose rate changes based on purchase documentation.

## L. Transition Plan

Moving from an AWP-based reimbursement methodology to an AAC-based approach will align pharmacy provider reimbursement with the actual costs of dispensing prescriptions; however program conversion will not be a simple task. The following are factors that will need to be considered prior to AAC program implementation.

- Establishment of a project timeline
- Determination of SPA and Rule sections for modification
- Schedule for stakeholder meetings
- Plan for fiscal intermediary to attain AAC rates
- Inventory of programming changes needed and schedule for completion by fiscal intermediary
- Development of procedures for provider support services

## M. Conclusion

Reducing reimbursement for prescription services is an area that is often met with provider resistance. Providers have relied on Medicaid to be one of the best payers and contribute to their pharmacy profit. The Division does not seek to eliminate pharmacy profit but does desire to promote efficiency as a means to profitability. Pharmacies that develop or continue efficient means of acquiring and dispensing prescriptions pharmaceuticals will still have opportunity to grow within the new methodology.

The Division understands the importance of being good stewards of tax payer money. One of our goals is to maintain access to prescription services for our enrollees. Due to the pending changes in CMS' proposed February 2012 Proposed Rule, it is necessary to transition into a reimbursement methodology that fulfills the proposed requirements of CMS and ultimately a methodology that provides transparency and reliability into a complex and sensitive area of reimbursement. We feel that the above recommendations will achieve this goal and also create avenues for growth in the pharmacy profession.

The Division is pleased to have the opportunity to present this report in response to House Bill 421.

**Appendix A**

# Net Fiscal Impact of Proposed Program Changes

**Model to Project Fiscal Impact of Proposed Program Changes (State and Federal Dollars)**
**Rebase Rates from June 2012: Annual Fiscal Impact**

| Estimated Savings Due to proposed AAC Rates for Brand & Generic Drugs | State and Federal | State |
|---|---|---|
| Estimated Savings for Generic Legend Drug Groups[1] | ($48,433,788) | ($12,868,857) |
| Estimated Savings for Brand Legend Drug Groups[1] | ($8,633,653) | ($2,293,962) |
| | | |
| **Projected Total Savings from proposed AAC Rates[1]** | ($57,067,441) | **($15,162,819)** |
| **Estimated Savings Due to proposed Change in EAC for non AAC Drugs** | **State and Federal** | **State** |
| Estimated Savings for Generic Legend Drug Groups with no AAC[2] | ($63,080) | ($16,760) |
| Estimated Savings for Brand Legend Drug Groups with no AAC[2] | ($2,873,768) | ($763,560) |
| | | |
| **Projected Total Savings from proposed Change in EAC for non AAC Drug Groups[2]** | ($2,936,848) | **($780,321)** |
| **Estimated Savings Due to proposed Change in EAC for OTC Drugs** | **State and Federal** | **State** |
| **Projected Total Savings from proposed Change in EAC for OTC Drug Groups[3]** | ($231,377) | **($61,477)** |
| **Estimated Costs Due to the Increase in Dispensing Fee** | **State and Federal** | **State** |
| Claims for drugs (Generic Legend) | 3,105,975 | |
| Claims for drugs (Brand Legend) | 809,163 | |
| Claims for drugs (OTC) | 392,340 | |
| Current Generic Dispensing Fee | $4.91 | |
| Current Brand Dispensing Fee | $3.91 | |
| Current OTC Dispensing Fee | $3.91 | |
| Estimated Expenditure for Current Generic Dispensing Fees | $15,250,337 | $4,052,015 |
| Estimated Expenditure for Current Brand Dispensing Fees | $3,163,827 | $840,629 |
| Estimated Expenditure for Current OTC Dispensing Fees | $1,534,049 | $407,597 |
| Total Estimated Expenditure for Current Dispensing Fees | $19,948,213 | $5,300,240 |
| | | |
| **Proposed Dispensing Fee** | $10.65 | |
| Total Claims for drugs (Legend Generic/Brand, and OTC) | 4,307,478 | |
| Proposed Dispensing Fee Expenditure | $45,874,641 | $12,188,892 |
| | | |

| | | |
|---|---|---|
| **Projected Total Costs of Increase in Dispensing Fee** | $25,926,428 | **$6,888,652** |
| **Combined Statistics** | **State and Federal** | **State** |
| Projected Total Savings from proposed AAC Rates[1] | ($57,067,441) | ($15,162,819) |
| Projected Total Savings from Change in EAC for non AAC Drug Groups[2] | ($2,936,848) | ($780,321) |
| Projected Total Savings from proposed Change in EAC for OTC Drug Groups[3] | ($231,377) | ($61,477) |
| Projected Total Costs of Increase in Dispensing Fee | $25,926,428 | $6,888,652 |
| | | |
| **Projected Annual Fiscal Impact of proposed AAC rates, Change in EAC for non AAC Drugs, and the Increase in Dispensing Fee** | ($34,309,238) | **($9,115,965)** |

**Notes:**

1. Based on proposed AAC rates reflective of June 2012 invoice data.

2. Proposed reimbursement defined as the lower of WAC and FUL.

3. Proposed reimbursement for generic OTC products is the lower of AAC and FUL. If there is no AAC, then the lower of WAC and FUL.

3. Proposed reimbursement for brand OTC products is AAC. If there is no AAC, then WAC.

* State share of expense/savings calculated based on FMAP of 73.43% for FY 2013.

* Claims based on Mississippi claims data with dispensed dates between 7/1/2011 and 6/30/2012.

* Actual submitted charges and amounts paid were not considered, estimated savings based on units dispensed.

* Data from First Databank used in analyses current as of June 30, 2012.

* Impact of Nutritional and Non-Drug claims were excluded from the analyses.

* Negative numbers, in parentheses, reflects savings to the State and positive numbers reflect additional cost to the State.

**Appendix B**

# Generic Spend per Claim from FFY2010 CMS Drug Utilization Data

**Ranking of States by Generic Spend Per Claim (Federal Fiscal Year 2010)**

| Rank | State | Number of Generic Claims | Total Generic Reimbursement | Generic Spend per Claim |
|---|---|---|---|---|
| 1 | MAINE | 4,730,080 | 31,676,058 | $6.70 |
| 2 | OHIO | 18,696,370 | 194,108,721 | $10.38 |
| 3 | IOWA | 2,293,923 | 27,891,422 | $12.16 |
| 4 | INDIANA | 7,993,473 | 98,505,260 | $12.32 |
| 5 | PENNSYLVANIA | 5,916,337 | 74,764,030 | $12.64 |
| 6 | WISCONSIN | 9,548,914 | 129,560,727 | $13.57 |
| 7 | MASSACHUSETTS | 6,524,994 | 88,878,277 | $13.62 |
| 8 | MICHIGAN | 5,242,321 | 72,215,475 | $13.78 |
| 9 | NEBRASKA | 2,240,322 | 31,531,427 | $14.07 |
| 10 | TENNESSEE | 8,894,694 | 129,400,957 | $14.55 |
| 11 | NEW YORK | 36,378,352 | 595,128,029 | $16.36 |
| 12 | DISTRICT OF COLUMBIA | 776,994 | 12,746,931 | $16.41 |
| 13 | NEW JERSEY | 12,113,278 | 199,779,237 | $16.49 |
| 14 | IDAHO | 1,330,033 | 21,991,983 | $16.53 |
| 15 | KENTUCKY | 8,110,859 | 134,975,509 | $16.64 |
| 16 | WEST VIRGINIA | 3,314,116 | 56,294,025 | $16.99 |
| 17 | NEW HAMPSHIRE | 964,667 | 16,486,557 | $17.09 |
| 18 | CONNECTICUT | 6,221,180 | 107,155,086 | $17.22 |
| 19 | FLORIDA | 19,726,150 | 341,836,416 | $17.33 |
| 20 | OREGON | 1,414,266 | 24,889,905 | $17.60 |
| 21 | OKLAHOMA | 4,133,324 | 73,243,962 | $17.72 |
| 22 | GEORGIA | 5,373,594 | 95,445,427 | $17.76 |
| 23 | DELAWARE | 1,479,439 | 26,365,015 | $17.82 |
| 24 | SOUTH CAROLINA | 2,657,725 | 47,485,348 | $17.87 |
| 25 | VIRGINIA | 3,157,913 | 56,569,621 | $17.91 |
| 26 | NORTH DAKOTA | 409,352 | 7,435,239 | $18.16 |
| 27 | SOUTH DAKOTA | 575,718 | 10,544,586 | $18.32 |
| 28 | MARYLAND | 2,073,418 | 39,721,783 | $19.16 |
| 29 | NORTH CAROLINA | 10,360,984 | 199,363,590 | $19.24 |
| 30 | ALABAMA | 5,915,902 | 120,750,387 | $20.41 |
| 31 | VERMONT | 922,174 | 19,146,213 | $20.76 |
| 32 | ARKANSAS | 3,241,801 | 69,908,348 | $21.56 |
| 33 | COLORADO | 2,440,851 | 53,562,893 | $21.94 |
| 34 | TEXAS | 22,056,354 | 484,797,400 | $21.98 |
| 35 | CALIFORNIA | 19,731,894 | 451,492,813 | $22.88 |
| 36 | UTAH | 1,791,176 | 41,171,895 | $22.99 |
| 37 | MISSISSIPPI | 3,980,678 | 102,924,141 | $25.86 |
| 38 | ALASKA | 718,904 | 19,769,794 | $27.50 |
| 39 | LOUISIANA | 7,216,728 | 205,360,827 | $28.46 |

**Source**: CMS 2010 Drug Utilization Review Report available from CMS website

**Notes**: States that do not have a 2010 DUR report available on website are excluded from ranking